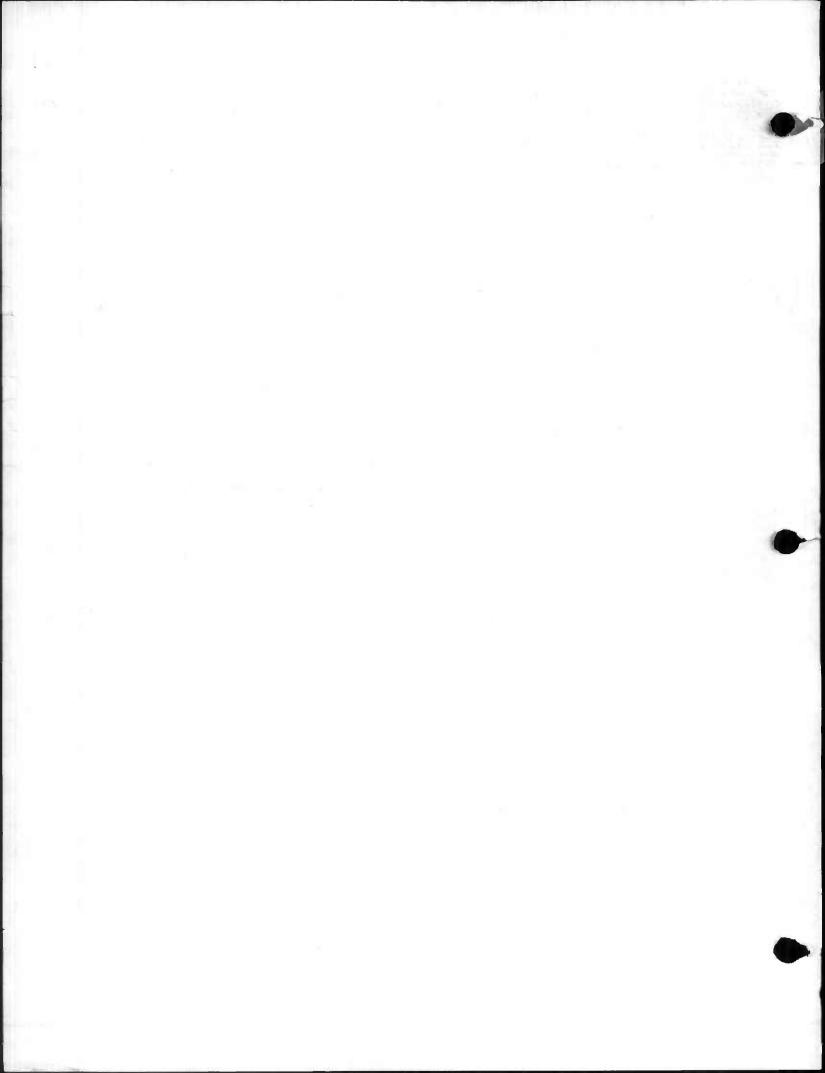
State of Maryland / Department of Health and Mental Hygiene 9 7

27001

| | | | | | Certin | ficate o | of Death | | Reg. No. | 1 | 21001 |
|--|--|---|--|--------------|---|--|--|-------------------------------------|------------------------------------|----------------------------|---|
| Physician /Medical | 2 | | orsey, S. | mith | , | | | 2. Dete of D Month Septemb | eeth | Yeer 97 | 3. Time of Death 955pm |
| Examiner | 4e. Facility N | Name (If not institution, gi I Hopkins & | ve street end number) | dical | Center | | 4b. City, Town, or Baltimor | | | of Deeth | |
| Funeral Director | 217- | 66-4271 | Sex 7. Ag 1 □ M 2 □ F | | | Under 1 Yellonths Dey | | 8. Dete of B (Month, D | irth ey, Year) 4, 56 | 9. Birthpl Coun | lece (State or Foreign try) |
| r 28a-f show notified at rector | 10a. Stete | 10b. County | non | | Town or Locati | | | | | 10 | 0d. Inside City Limits |
| | 10e. Street e | and Number 8 Arunah St. | | | | 10f. Zip Code | 1216 | | 10g. Citizen of | | ntry? |
| Examine must | 3 □ Wide | itetus er Merried 2 Married bwed 4 Divorced | 12. Wes Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Yeer or Detes: | - | If Ye | Decedent of second of the seco | of Hispanic Origin? (Suban, Mexican, Puer No Specify: | Specify Yes or N to Ricen, etc.) | | | |
| d other than nature event, the Medical Be Completed | Elementer 1/2 TH | 15. Decedent's E (Specify only highest gr ry/Secondery (0-12) GRADE Neme (First, Middle, Last | ede completed) College (1-4or ! NA | | 16e. Decedent (Give kind life. DO | d of work dor NOT use reti | ne duning most of wo ired) | | 16b. Kind of B | CARE | |
| and Man is marke numetic | | SMITH ant's Neme/Relationship. | | | | | HELENA eet end Number or Ri | - | ber, City or Town | , Stete, Zip | Code) |
| Department of Health a Important: if frem 27 is any injury or other trai once. | 1 ☑ Buri 4 ☐ Don | HOMPSON of Disposition ial 2 □ Cremetion 3 E netion 5 □ Other (Speci | fy) | 20b. Pla | G MEMO 22. N. VAUC | RIAL I | ARK dress of Fecility GREENE | 9 10 97 FUNERAL | RANDAU SERVICE | STOWN | N, MO |
| ysician Medical taminer | 23e. Pert1. shock, tmmediete disease or cresulting in contract. | ondition | | iac a | rest / | Pulsele | NATE PIL dylng, such es cerdle | c or respiretory | errest, | SLL. | Approximete Intervel Between Onset end Death |
| niner niner | | | b. Prec | (MON | es a consequer | nce of): | | | | | 1 mmts |
| physician and is the buriel-transit | thet initieted | events | C | roder | | | | | | | 15years |
| Z e ii | resulting in o | deeth) Last | d | Due to (or | es e consequen | CO 01). | | | | | |
| ed by the ettend deteched for us, Y Physician/ | Pert II. Other | significant conditions of | contributing to deeth b | ut not resul | lting in the unde | rlying cause | given In Pert I. | 23b. Did | I tobacco use co | ntributa to | the cause of death? |
| | | | | | | | | 10 | Yes 2□ No | 3 Prob | pably 4 Unknow |
| 2 should | | | | | | | | 24a. Wei | s en autopsy ormed? | ava | ere eutopsy findings ailable prior to mpletion of cause deeth? |
| certificate he rector, page | 25 Was cas | e referred to medical | | | | | | | Yes 2 No | 1 🗆 | Yes 2□ No |
| fler this unerel di | 2 1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Spec | | | | | | | | | <i>(</i>) | |
| within 24 hours siter death. To the Funeral Director: After to completely filled in by the funeral Medical Certification: | 2 Accident Investigation 3 Suicide 4 Homicide 5 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 7 Homicide 7 Homicide 7 Homicide 8 Homicide 7 Homicide 8 Homicide 7 Homicide 7 Homicide 7 Homicide 8 Homicid | | | | | | | | wn, Stete) | | |
| he Funer pletely fill edical | 29e. Certifier (Check one) | 1 Certifying Phonly 2 Medical Exam | nysician: To the best of miner: On the basis of end menner ste | examinetic | iedge, deeth oc on end/or invest | curred et the igetion, in my | time, dete end plece y opinion, death occu | e, end due to the | ceuse(s) end me dete end piece, | anner as sto end due to | eted. the ceuse(s) |
| To the complete of the complet | 29b. Signetu | re and title of certifier (I Euladea) | , 10 | | | | nse number 2664200 - C | 150 | Jep 7 4 | | |
| | 00.41 | d eddress of person who | | | | | | | | - | |



State of Maryland / Department of Health and Mental Hygiene 97 27002

| | | | | | _ | Ce | rtificate | of D | eath | | Re | eg. No. | 1 6 | . 1002 |
|--|-----|--|----------------------|---|---|---------------------------------------|---|--------------------|-----------------------------|----------------------|--|----------------------------------|---|---|
| ysician | | I. Decedent's Name (First, Min | idie, Las | u) | | | | | | | 2. Date of Deat | h Day | Year | 3. Time of Deal |
| Medical | | Frances | | R | • | | Smith | | | S | ept. | | 97 | 6:11AM |
| aminer | ľ | a. Facility Neme (If not institu | - | | imber) | | | | | | ation of Death | 4c. County | of Death | |
| | ۹, | Stella Maris | | | | | Milledge d 3 | | 'imoni | | | | imore | |
| ai or | | Social Security Number 232-72-8712 | 6. Se | ex □M 2∰F | 7. Age (In) | yrs. last birthday) 6 Yrs. | Months D | Deys | If Under 24 Hours | Min. | B. Date of Birth (Month, Day, Pril 9 | 1911 | 9. Birthpla Countr Vir | ce (State or For y) ginia |
| | - | Usuel Residence of Decedent Oa. State 10b. Cour | tv | | 10c | City, Town or Lo | ncation | | | | | | 110 | d. Inside City Lin |
| 5 | | | imo | ro | | | | | | | | | | 1 ☐ Yes 2 ☒ |
| Director | - | Oe. Street and Number | - IniO | re | | Towson | 10f. Zip Co | n el e | | | 4 | On Oldinan of 1 | Affron Course | |
| | | 711 Steven | on : | Lane | | | 21 | 204 | | | | 0g. Citizen of \ | USA | yr |
| by Funeral | | 1. Marital Status 1 □ Never Merried 2 → M 3 □ Widowed 4 □ Divord | | 12. Wes Dec Armed Fo 1 Yes If Yes, Gi Year or D | orces? 2 🔼 No ive | | Was Deceden if Yes, specify 1□ Yes 2☒ | | | n? (Spec Puerto R | ify Yes or No- ican, etc.) | | e - America ck, White, et /: Wh: | |
| e e | | 15. Deced (Specify only hig | | | | 16a. Dece | dent's Usuel C kind of work of DO NOT use i | Occupat | tion | f working | | 16b. Kind of Bi | usiness/indu | istry |
| Completed | | Elementery/Segondery (0-12 | | | 1-4or 5+) | | iomemak | | ining most o | i working | | Own : | Home | |
| To Be C | | 7. Fether's Name (First, Midd Robert | e, Last) | Hill | | | Rudd | | 18. Mother's Ruby | Name (| First, Middle, M | Maiden Suman | 7e) | Sims |
| To | 1 | 19e Informent's Name/Relation James W. Smith | | | | | | | | | Route Number WSON , MD | | | Code) |
| | 2 | 0a. Method of Disposition | | | 20 | b. Place of Dispo | sition (Name | of | | | - T | 20c. Location - | | n, State |
| | | 1 A Burial 2 ☐ Cremetio 4 ☐ Donation 5 ☐ Other | - | | Stete S | cometery, creation kin Quar | | | | 9- | 8-97 | Mosely | ,Virgi | inia |
| SUCE | | 21. Signature of Funeral Servi | e Licen | 00_ | _ | 22 | Name and A Ruc 105 | k T | owson | Fun- | eral Ho | me,Inc | | |
| | 1 | 23a. Part1. Enter the disease, shock, or heart failure. L | or comp | lications that one cause on e | caused the deach line. | eath. Do not ent | | | | | | | 1 | Approximete nterval Between Onset end Death |
| n al | | mmediate Ceuse (Final | | | 141 | | £ . | | | | | | | Jiset end Death |
| ner | r | disease or condition resulting in death) | | a | | tiple I | | De | menti | a | | | 1 | |
| ě | | | | | | o (or es e consec . Stage (| | | | | | | 1 | |
| Examiner | | b | | | | | | | | | | | | - |
| ŭ | | Sequentially list conditions, f any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury | J | | | 104047004 | | | | | | | | |
| Medical | 1 | bause (Disease or injury hat initiated events resulting in death) Last | 5 | C | Due to | o (or as a conseq | uence of): | | | | | | - | |
| Me. | | | L | d | | | | | | | | | 1 | |
| letached for use as the burlet-transit Physician/Medical Examir | | | | u | | | | | | | | | | |
| detached f | F | art ii. Other significant cond | tions co | ntributing to d | eath but not | resulting In the u | nderlying caus | se giver | n in Part i. | | 23b. Did to | bacco use co | ntribute to 1 | the causa of dea |
| Ph P | | | | | | | | | | | 1 □ Y | S 2 No | 3 Probe | ibiy 4 🗆 Unkn |
| 2 2 | 1 | | | | | | | | | | | | T | |
| pege 2 should | | | | | | | | | | | 24e. Was ai | n autopsy ned? | avai | e autopsy finding lable prior to pletion of cause |
| npi | . - | | | rgs. | | | | | | | | | of de | eath? |
| Com | | | | | | | | | | | 1□ Ye | s 2 No | 1 🗆 | Yes 2□ No |
| orrector. | 2 | 25. Was case referred to medi examiner? | - | | | | | | 26. Plece o | f Deeth | Check only on | Θ) | | |
| | | 1 ☐ Yes 2 R No | | Hospital: 1 □ | Inpatient 2 | ER/Outpatier | t 3□ DOA | Other | 4 □ Nurs | ing Home | e 5 🗆 Reside | nce 6 AOth | er (Specify) | HOSPIQ |
| ion: | 2 | 7. Manner of Deeth 1 Netural 5 □ Pen | lina | 28a. Date (Mon | of Injury th, Day Year | 28b. Time or | 28c. | Injury i | at | 28 | d. Describe ho | w Injury occur | red | |
| S S | | 2 Accident Inve | tigetion d not be | | | at home, farm, str | М | 1 🗆 Y | es 2 No | | f. Location (St | reet and Numb | ner or Rural | Route Number |
| Certification: | | 4 Homicide dete | mined | buildi | ing, etc. (Sp | ecify) | out, lactory, 0 | | | 20 | City or Town | , State) | . G. G. FIGIGI I | |
| Medical Certifi | | 29a. Certifier 1 Certifier 1 Certifier 2 Medic | Ing Phy ni Exami | iner: On the b | best of my l asis of exam ner stated. | knowledge, death ination and/or in | occurred at t restigation, in | the time my opi | , date and p nion, death | occurred | d due to the ce l at the time, da | ouse(s) and ma ate and place, | inner as sta and due to t | ted. he cause(s) |
| Me | 26 | 196. Signature the tiple of cont | of. | î ^ | 5) | | 29c. L. | icense | number 550 | 4 | | 9d. Dete signe | - | ey, Yeer) |
|) | 3 | 0. Namerand address in pass | who o | completed caus | se of death | ttom 23a) (Type | Perusaca | , (| Is May | ho | 2/ | 204. | | |
| | - | 4 Date (2) 1 (2) 2 | | | | | | | | | | | | |
| State | 3 | 1. Date filed (Month, Day, Yes | r) | 32. F | legistrer's Si | gnature | | | | | | | | |
| gistrar | L | SEP 0 8 1997 | | granian | kurdsen. | -Adaphable | | | | | | | | |
| N 6/95 | | A STATE OF THE STA | | 9 | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Casth 2 Date of Death Month **Physician** rank 1305 /Medical 4a. Facility Name (If not institution, give street and number) 9633 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Healtway General Hospital Atlantic Berlin Worcester prive If Under 24 Hrs. 8. Date of Birth (Month, Dev. Year)
ADTIL 29, 1925 If Under 1 Year 5. Social Security Number 193-14-2540 9. Birthplace (State or Foreign Country)
Pennsylvania 7. Age (In yrs. last birthday) **Funeral** 10 M 27 F Deys Director Usuel Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show XX Yes 2 No Director Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 8 611 Hollen Road 21212 USA 12. Was Decedent Ever in U,S.
Armed Forces?

XXI Yes 2 □ No
If Yes, Give
Year or Dates: WWII Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Merried XX Married 21215-00gg 1 ☐ Yes XX No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Data Processing Supervisor Social Security Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Pages 1 and 2 should be I nent of Health and Mental I ant: If Item 27 is marked or Robert Fleming Stitt Lela Minerva Fitzgerald 19a. informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at important: if Item 27 is any injury or other trau-once. Frances L. Stitt Wife 611 Hollen Road Baltimore, Maryland 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, State 1 ☐ Burial 2 💢 remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cemetery 9/5/97 Baltimore, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212 complex ons that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, built only any sause on each line. Approximate Interval Between Onset and Death **Physician** /Medical immediate Ceuse (Final He mop tysis
Due to (or as e consequenca of): diseese or condition resulting in death) Examiner Physician/Medical Examiner cancer of colon, lung, brain unknown and I-fransit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Box 68760. the Due to (or as a consequenca of): 98 P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the causs of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records. þ 24b. Were eutopsy findings available prior to Completed 24e. Was an autopsy completion of cause of death? 1 Yes 2 PNo 1 ☐ Yes 2 ₺ No Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury
(Month, Day Year) 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury at Work? After 5 Pending investigation To the Hospital or Attending within 24 hours effer death.

To the Funeral Director: After the Funeral Director of the 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homleide 175 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner as steted.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) Thomas Treemvood My D-48130 30. Neme end address of person who completed cause of death (Item 23a) (Type, Print) Healthway Orme, Berlin Maryland Jeffrey Thomas Greenwood

State Registrar

31. Date filed (Month, Day, Year)
SEP 0 8 1997

32. Registrar's Signeture

DHMH 16 Ray 6/95

State of Maryland / Department of Health and Mental Hygiene 97

27004

| | | | | | C | ertificati | e of | Death | | F | Reg. No. | | - 10 | 0 1 |
|-------------------|--|---------------|---|---|--|--|-----------------------|------------------------------|--------------------------|---|------------------------------|---|---|----------------------|
| | Dharaini | | 1. Decedent's Name (First, Middle, La | st) | | | | | | 2. Data of Dea Month | - | Vaar | 3. Tima o | f Death |
| | Physici /Medi | | Mary Claire | Sullivan | | | | | | August | 28 28 | 1997 | 4:00 | PM |
| 1 | Examir | | 4a. Facility Name (If not institution, giv | | | | | 4b. City, To | wn, or Lo | cation of Death | 4c. Cou | nty of Death | | |
| Ĺ | | | 1 Smeton Place | Apt. 503 | | | | Tows | | | Bal | timore | | |
| | Funeral Director | | 5. Social Security Number 6. S 214-01-1177 Usuel Residence of Decedent | 7. Aga (In) | vrs. last birthda Yrs. | Months | 1 Yaar Days | | 24 Hrs. Min. | 8. Date of Birth (Month, Day May 3, 1 | | 9. Birthi Cour Mary | placa (State ntry) land | or Foreign |
| | Mow M | | 10a. Stata 10b. County | 10c. | City, Town or | Location | | | | | | 1 | IOd. insida C | City Limits |
| | h the Maryland r 28a-f show s.notified.at | Director | Maryland Baltin | more | Tow | SON 10f. Zip | Code | | | | 10g. Citizen | of What Cou | | 2 XX |
| | a 23a or nunt be | | 1 Smeton Place # | | | | 120 | | | | l | JSA | | |
| 21215-0020 | 72 hours after death with the Marylar Instirral, or items 23s or 23s-f show dissi Examiner must be notified at | d by Funeral | 11. Marital Status 1 □ Never Married 2 □ Married 3 ♥ Widowed 4 □ Divorced | 12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Dates: | n U,S. 13 | 3. Was Deced If Yes, spec 1 ☐ Yes | ify Cub | oan, Mexicar | , Puerto | ecify Yes or No- Rican, etc.) | | lace - Americ llack, White, clfy: | | |
| 3 | 72 h natu disal | Completed | 15. Decedent's Ed (Specify only highest gra | flucation de completed) | 16a. Dec | cedent's Usua ve kind of wor . DO NOT us | i Occu rk done | pation during mos | t of worki | na | 16b. Kind of | Business/In | dustry | |
| 12 | Part Part Part Part Part Part Part Part | ıdμ | Elementary/Secondary (0-12) | College (1-4or 5+) | | | | ed) | | | | | | |
| 22 | THE | ပိ | 12 17. Father's Name (First, Middla, Last) | | | Homema | ker | 18 Mothe | r'e Name | (First, Middle, | | Own Ho | me | |
| ylen | | To Be | John Bernard Cai | 1 | | | | C | lara | Meecha | m | | | |
| g/ | | 9 | 19a. Informant's Name/Relationship (| | | | | | | I Route Numbe | | | | |
| e, | -116 | | Paul Sullivan 20a. Method of Disposition | Son | | | | | enue | Baltimo | | n - City or To | | 0 |
| Baltimore, | permit. Pages Department of Important: If It any injury or o | | 1 ☐ Burial 2) Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific | () | Place of Dis cemetery, con Penmo | | | | 9/ | | Baltin | | | ınd |
| Bal | Departiment of the post of the | | 21 Signature of Funeral Serfice Licer | Tenlena | 11 | 22. Name an | | | MI | tchell- imore, | | | | |
| į | Physician [®] | 1 | 23a. Part1. Enter the disease or companies shock, or heart failure. List only | * | eath. Do not e | enter tha mode | e of dy | ing, such as | cardiac o | or respiratory are | rest, | | Approxima Interval Be Onset and | te tween Deeth |
| 9 | /Medical | | Immediate Cause (Final disease or condition | Acu | to | W 40 C | 0.0 | lind | 14.1 | actor | 10 | | Mini | to |
| | Examiner | | resulting in death) | a. Due to | o (or as a cons | sequence of): | 70 | a con | 1117 | y all | /1 | 1 | 1 (1 4 | .7 |
| | uted d ansit | Examiner | Sequentially list and living | b | poxen | Ma | | | | | | | Hants Veo | 45 |
| Ö, | e exectant and | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | 50.7 | (or as a cons | | P | D | | | | 1 | Voa | . < |
| x 68760, | es that the death certificate be executed gned by the attending physician and be datached for usa as tha bunal-transit | /Medical | Cause (Disease of Injury that initiated events resulting in death) Last | Due to | o (or as a cons | equenca of): | | P | | | | | 160 | <u></u> |
| Bo | atten affor u | clan | David Other day March | | | | | | | 1 | | i | | |
| P.O. | that the d ed by the datachec | / Physician | Part II. Other significant conditions of | 1 | resulting In the | underlying ca | ause gi | ven in Part I | | 23b. Did to | obacco use ′es 2□ Ne | | o the cause bably 4□ | |
| Records, | v requir been s should | Completed by | | | | | | | | 24e. Was a perfor | an autopsy med? | av | ere autopsy allable prior mpletion of death? | to |
| | The ate h page | Com | | | | | | | | 1 🗆 Y | es 2 No | 1[| ☐Yes 2☐ |] No |
| Ita | entification, | Be (| 25. Was case referred to medical examiner? | | | | 1 | 26. Place | of Deeth | (Check only or | ne) | | | |
| > > | 00 | 10 | 1 ☐ Yes 2 No | Hospital: 1 Inpatient 2 | ER/Outpat | ient 3□ DO | A Ot | her: 4□ Nu | rsing Hor | ne 5 Resid | ence 6 🗆 0 | Other (Specif | y) | |
| Division of Vital | Attending Physician: or death. ector: After this certific by the funeral director, | ertification: | 27. Manner of Death 1. Naturai 5 ☐ Pending 2 ☐ Accident investigation | 28a. Date of Injury (Month, Day Year | 28b. Time Injury | of 2 | 8c. Inju Wo 1 [| nyat ork?]Yas 2□ | 1 | 28d. Describe h | ow injury occ | curred | | |
| Divis | il or Attend after death Director: / d in by the i | ertific | 3 Suicide 6 Could not be determined | 28e. Piaca of Injury - A building, etc. (Spe | t home, farm, socify) | street, factory | , office | | 2 | 28f. Location (S City or Tow | | mber or Ruri | al Route Nun | nber, |
| | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral | edicai C | 29a. Certifier (Check only one) 1 Certifying Ph. 2 Madical Exam | ysician: To the best of my lainer: On the basis of exam and manner stated. | nowledge, de Ination and/or | ath occurred a invastigation, | at the ti | ime, date an opinion, dea | d place, a th occurre | and due to the co | ause(s) and lete and plac | manner as s a, and due to | tated. the cause(| s) |
| | vithin Fo the | Me | 29b, Signature and title of certifier | | | 290 | Licen | se number | | 2 | 29d. Date sig | ned (Month, | Day, Year) | |
| | | | 1 2h W | aul on | 10 | | 1)8 | 74- | 2/ | | 8- | 29- | -97 | 1 |
| | 12 | | 30. Name and address of person who | completed cause of deet | 13a /4 | e, Print) | 46 | | 2/2 | .28 | | | , , | Barrier and States |
| | Sta | te | 31. Date filed (Month, Day, Year) | 32. Registrar's Si | natura Pand | _ | , – | ol. | -[- | | | | | |
| | Registr | | SEK 0 8 1331 | June world | Maria Maria | CANAD . | | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene 9 7

27005

| | | | | | Certificate of | of Dear | th | F | Reg. No. | | 4,000 |
|--|------------------|--|---|-------------------|--|-------------------------------|---------------------------|--|-----------------------------------|---------------------------|--|
| | | 1. Decedent's Name (First, Middle, La | st) | | | | | 2. Date of Dea | ath | | 3. Time of Death |
| Physic | | JOHN SHIPLES | 1 | | | | | Month | 7.8 / | Year 997. | 10-15 AM |
| /Medi Exami | | 4a. Facility Name (If not institution, giv | | | | 4b. City, | Town, or L | ocation of Death | | | 10 17 ATT |
| LAGIIII | ICI | HARBOR HOSPI | | 2570 | | _ | | E, MD. | 270 | | M.L. |
| | | 5. Social Sacurity Number 6. 5 | | (In yrs. last bin | thday) If Under 1 Y | | der 24 Hrs. | | | timo | |
| Funeral | | | 180 M 2□ F | | Yrs. Months Da | | | 8. Data of Birth (Month, Da) | Year) | 9. Birthe | place (State or Foreign |
| Director | | Usual Rasidanca of Decedent | | 70 | | | | May 16, | 1919 | Pen | nsylvania |
| P | | 10a. State 10b. County | | 10c. City, Town | n or Location | | | | | 1 | IOd. Inside City Limits |
| (a) 45 M | ច | Maryland N/A | | Ra1+ | imore | | | | | | 1XX Yas 2 □ No |
| eath with the Maryland is 23e or 28e-f show must be notified at | 6 | 10e. Street and Number | | 2410 | | (a) | | | 10 000 | | |
| 6 9 | ក់ | | | | 10f. Zip Coo | | | | 10g. Citizen of | | stry? |
| 23 and 23 | a | 1516 Cypress Sti | _ | | 21 | 226 | | | U.S | · • | |
| 9 10 | Funeral Director | 11. Mantai Status | 12. Was Decedent E Armed Forcas? | | 13. Was Decedent If Yes, specify (| of Hispanic Duban, Mexi | Origin? (Spican, Puerto | pecify Yas or No- Rican, etc.) | | ce - Americ ck, Whita, | |
| 1 | | 1 ☐ Never Married 2 ☑ Married | 13€ Yes 2 □ N If Yes, Give | 0 | 1□ Yes 2X | | | | Specif | | |
| Es. 5 | d by | 3 Widowed 4 Divorced | Year or Dates: W | .W. II | | opus | | | Specii | W. WI | nite |
| 位于伊 | Completed | 15. Decedent's E. (Specify only highest gre | | 16a. | Decedent's Usual Or | cupation | nost of work | king | 16b. Kind of B | usiness/in | dustry |
| 1 | ig. | Etementary/Secondary (0-12) | College (1-4or 5- | +) | (Give kind of work de life. DO NOT use re | tired) | 1001 07 11011 | g | | | |
| 133 | 00 | 11th | | | Custodian | | | | Chu | rch | |
| TE SE | Be (| 17. Father's Name (First, Middle, Last, | | | | 18. Mc | other's Nam | e (First, Middle, | Maiden Sumar | ne) | |
| marked imatic ev | To | G | illespie E | . Shipl | .ey | | Ma | ary E. W | ilson | | |
| DEE | | 19e. Informant's Name/Reletionship (| Type, Print) | 19b. | Mailing Address (St | reet end Nur | mber or Ru | ral Route Numbe | r, City or Town | State, Zip | Code) |
| end 2 alth er 27 is er trau | | Ruth I. Shipley | / wife | 15 | 516 Cypres | s Stre | eet | Baltim | ore, Ma | rvla | nd 21226 |
| othe othe | | 20a. Mathod of Disposition | | 20b. Piace of | Disposition (Name o | 1 | | Date | 20c. Location | | |
| nent of I | | 1 X Burial 2 ☐ Cremation 3 ☐ | | | y, crematory or other | | | 9/2/97 | | | |
| Trant | | 4 Donation 5 Other (Specif | | Ma. St | ate Veter | | | 0/2/91 | CLOWIISV | 'IIIe | , Maryland |
| permit. Pages Depertment of Important: If it any injury or once. | | 21. Signature of Funeral Service Licer | 1966 | / | 22. Nama and Ad | Idrass of Fa | cility | Gonce F | uneral | Home | P.A. |
| 7 D = 4 O | | Herome In | emiseu | we | 4001 Rite | chie F | Highwa | ay Balt | imore, | Md. | 21225 |
| | | 23a. Part1. Enter the diameter or com shock, or heart failure. List only | plications that caused | tha death. Do r | ot enter the mode of | dylng, such | as cardiac | or respiratory ar | rest, | | Approximate Intervat Between |
| hysician | | | one sound on oddining | | | | | | | | Onset and Death |
| /Medicai | | Immediate Cause (Final disease or condition | a. END | STOGE | Emplay | 1612m | 0 | | | | 3 DAYS |
| xaminer | | resulting in deeth) | | | consequence of): | 136111 | 77 | | | | J DAYS |
| | Je. | | | | | 0 | 200106 | 24 DIS | 200 | 1 | Six Yenre |
| g physician and as the burial-transit | Examiner | Sequentially list conditions | D | | consequenca of): | 1 ULI | 101471 | 7 2/3 | C775C | 1 - | DIX IGHRS |
| ding physician and se as the burial-transit | EX | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | | 700 10 (0) 03 0 0 | onsequence or). | | | | | 1 | |
| sicia e bui | edicai | Cause (Disease or injury that initiated events | C | | | | | | | - | |
| phy st | be | rasuiting In death) Last | D | ua io (oi as a c | onsequanca of): | | | | | | |
| din | 8 | | d | | | | | | | | |
| etten I for u | ciai | | | | | | | | | | |
| 0 % | Physician | Part II. Other significant conditions of | ontributing to death but | not resulting In | the underlying cause | given in Pa | art I. | 23b. Did to | obacco uae co | ntributa to | o the cause of death? |
| dete dete | | - LEFT HE | MIGLOSSE | CROMY | | | | 101 | res 2 No | 3 Pro | bebly 4 Unknown |
| per de | d by | | | | | | | | | Tail | |
| ine lew requires trat the state has been signed by the page 2 should be detech- | Completed | - ACUTE 1. | PRINARY | REDEN. | mon. | | | 24a. Was a perfor | | av | ere autopsy findings ailable prior to |
| as b | ğ | | | 1 - 1210 | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | | of | mpletion of cause death? |
| page | ő | | | | | | | 1 🗆 Y | es 28 No | 10 | ☐ Yes 2☐ No |
| rtifica stor, | Be (| 25. Was case referred to medical | | | | 26. Pt | ace of Deat | th (Check only or | ne) | | |
| Is certificata has director, page 2 | TOE | examiner? 1 ☐ Yes 2⊠.No | Hospital: | t 2 ER/Out | tpatient 3 DOA | Other | | ome 5 Resid | | ner (Specif | v) |
| € 70 | | 27. Manner of Death | 28e. Date of tnjury | 28b. T | | njury at Work? | | 28d. Describe h | | | |
| within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, | 엹 | 1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Day | rear; Ir | | Work? 1 □ Yes 2 | □No | | | | |
| r des | TIC. | 3 Sulcide 6 Could not b | e 28e. Placa of Injur | y - At home, fai | rm, street, factory, off | ca | | 28f. Location (S | treet and Numi | ber or Rum | al Route Number, |
| Dire Jin t | Certification: | 4 Homicide | building, etc. | (Specify) | | | | City or Tow | | | |
| eral fille | | 29a. Certifier 1⊠ Cartifying Ph | velclen: To the best of | my knowlodgo | dooth populated at the | a time data | | and don to the | | | |
| Fun Fun | edicai | | ysician: To the best of niner: On the basis of e | examination and | Vor Investigation, In r | e time, date ry opinion, d | and placa, death occur | and due to the c red at the time, o | ause(s) and mi date and place, | anner as si and due to | ated. the cause(s) |
| within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral | Mec | 29b. Signature and titla of certifier | and manner stat | ed. | | ense numbe | | | | | |
| ₹ 6 | - | 200. Orginature and title of certifier | ON \ | | | | | - | 29d. Date signe | u (Month, | Day, raar) |
| V | | Unthe Pe | to Das | 01 | | 0643 | 3 | F | 7UGUST | 28 | , 1997 |
| 1 kg | | 30. Name end eddress of person who | completed cause of de | ath (Item 23a) (| Type, Print) | | | , . | _ | | |
| v | | | PASARO M. |), 300 | 1 5007-1 | HANG | OVER | STREET | BALTI | MORE | MARYLAND |
| Sta | te | 31. Date filed (Month, Day Year) SEP 0.8 1997 | 32 Registray | - Signature | 2.2.00 | | | | | | id id |
| Registr | ar | OEL 0 0 1331 | distant | MAY MOON !- / | arlange | | | | | | |

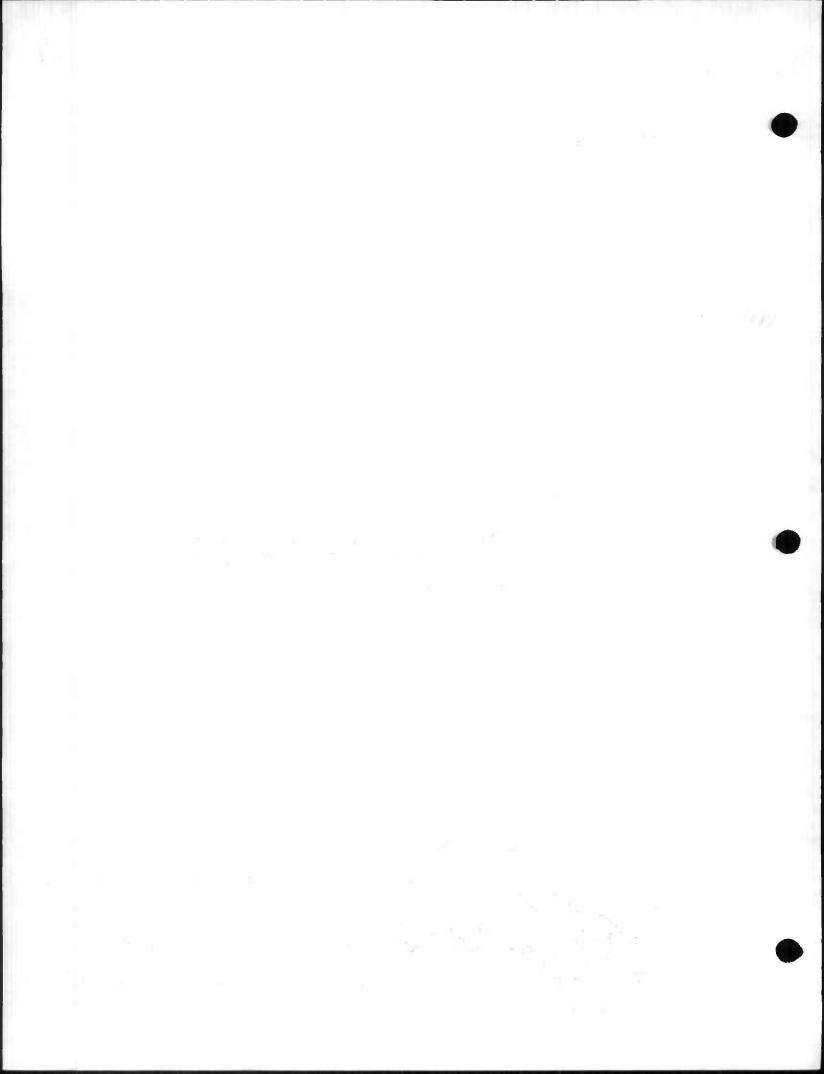
DHMH 16 Rav 6/95

State of Maryland / Department of Health and Mental Hygiene 97

e 97 27006

| | | | | | | Cei | rtificate | ot | Death | | | Reg. No. | | | |
|--|----------------|---|-----------------------------|-----------------------------------|--|------------------------------|--------------------------------|------------------|------------------------------|----------------------------|----------------------------------|-----------------------|---------------------------|-----------------|------------------|
| Physici | an | Decedent's Nam | ne (First, Middle, | | | | | | | 2 | . Date of Dea Month | ith Day | Yaar | 3. Time | e of Death |
| Physici /Medic | | GERDIN | E | | SINCL | AIR | | | | S | EPTEME | | 1997 | 143 | 30 P |
| Examir | | 4a. Facility Name (| (If not institution, | give street and n | umber) | | | | 4b. City, Tov | wn, or Loca | ition of Daath | 4c. County | of Death | | |
| | | SINAI | HOSP | ITAL | | | | - 1 | BALTI | MORE | E | NI | 9 | | |
| Funeral | | 5. Social Security I | | 6. Sex | 7. Aga (In yrs. la | , | If Under 1 Months | Year Days | If Under 2 Hours | 24 Hrs. g | . Date of Birti | h /. Year) | 9. Birthp Coun | lace (Sta | te or Foreign |
| Director | | 054-15 Usual Residence | | 1□M 2/DXF | // | Yrs. | | | | | SEPT | | 19 N | .CAI | ROLIN |
| death with the Maryland ms 23a or 28a-f show r must be notified at | tor | 10a. State MD | 10b. County | na | 10c. City, | Town or Lo | BAL1 | IM | ORE | | | | 1 | | City Limits |
| noti | Director | 10e. Street and Nu | ımber | | | | 10f. Zip C | ode | | | | 10g. Citizen of | What Coun | itry? | |
| ath with | Funeral D | 2614 | LOYOL | A NORT | CHWAY | | | | | 215 | | UNITE | D S | TATI | ES |
| de L | nne | 11. Marital Status | | Armed I | | 13. | Was Decede f Yes, specif | nt of F y Cub | lispanic Orig an, Mexican | oln? (Speci , Puarto Ri | fy Yes or No- can, etc.) | 14. Rad Bla | e - Americ ck, White, | | • |
| To the | by | 1 ☐ Never Man | rled 2 Marrie 4 Divorced | d 1 ☐ Yas If Yes, C Yaar or | s 2 ⊠ M o Give Dates: | | 1□Yas 2 | % | Specify: | | | Specif | y: B | LACI | K |
| 個口 | tec | (Sne | 15. Decedant's | Education grade completed | 1) | 16a. Deced | dent's Usual kind of work | Occup | ation | of working | | 16b. Kind of B | usiness/ind | Justry | |
| | Be Completed | Elementary/Sec | | | (1-4or 5+) | life. I | MAKEI | retire | d) | or working | | i n | own | hor | me |
| lental Hygical Red other | To Be C | 17. Father's Name ED | (First, Middle, L | • | | | | | 18. Mothe | r's Name (i | | Maiden Sumen C GAT | | | |
| th and Merit 7 is merited traumetic e | | 19a. Informant's N HEL | _ | p (Type, Print) OHNSON | -DAUG | 19b. Maitir | ag Address (| Street | end Numbe | r or Rurel F RRY | Route Numbe | BALTI | MORE | Code) MD | #23 |
| of Health Item 27 is r other tra | | 20a. Method of Dis | sposition | | 20b. Pla | ice of Dispo | sition (Name | of | | | Date | 20c. Location | | | |
| ent of nt: If it ry or o | | 20a. Method of Disposition 1 □ Furial 2 □ Cremation 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, cramatory or other place) KING MEMORIAT, P | | | | | | ARK | 9-9-9 | 7 RAN | DALL | STO | WN MD | | |
| Depertment of important: If any injury or once. | | 21. Signature of Fi | | | | | . Name and | _ | | | | | | | |
| Deperiment in any in an | | 16a | briel | 10, C | Dar? |) | WM. | C . | MARC | a fh | 430 | O WAE | BASH | AV | ENUE |
| - 1 | | 23a. Part1. Enter I | tha disease, or c | omplications that | caused the death. | Do not ant | er the mode | of dyir | ng, such as | cardiac or r | respiratory ar | rest, | T | Approxim | nate |
| ysician | | | | , | _ | | | | | | | | 1 | Onset ar | nd Death |
| Medical aminer | | Immediete Cause disease or condition | on | | SEPSIS | Š - | | | | | | | | | |
| amimer | | resulting in deeth) | | | Due to (or | as e consec | | | | | | | | | |
| # | ine | MYOCARDIAL INFARCTION | | | | | | | | | | | | | |
| physician and s the burial-transit | Examiner | Sequentially list conditions, if any, leading to immediate | | | | | | | | | | | | | |
| ician | | if any, teading to immediate cause. Enter Underlying Ceuse (Disease or Injury | | | | | | | | | | | | | |
| s the | /Medical | that initiated events resulting in deeth) | Last | | Due to (or a | as a conseq | uance of): | | | | | | i | | |
| nding p | | | | d | | | | | | | | | | | |
| e atte | Physicia | Pert It. Other aignit | ficant condition | s contributing to | death but not result | ting in the u | nderiving car | ise ah | en in Part I | | 23h Didt | obacco use co | ntribute to | the cau | e of death? |
| igned by the a be deteched f | hys | | | o continuoning to | 000000000000000000000000000000000000000 | ang an ano a | idonying out | 30 g. | on are aren. | | 100 | , | | | Unknow |
| peug ep ec | by F | | | | | | | | | | - 74 | | | | |
| en 10 | | | | | | | | | | | 24e. Was | an autopsy med? | | ere eutop | sy findings |
| s been 2 shoul | Completed | | | | | | | | | | peno | mear | CO | mplation death? | |
| 2 8 | E | | | | | | | | | | 1 D Y | es 2 No | | ☐Yes 2 | Nokio |
| | 0 | 25. Was case refer | rred to medical | | | | | | 26 Place | of Dooth (| Chack only o | | | 2 103 2 | ×100 |
| | To B | examiner? 1 ☐ Yes 2 🐧 | | Hospital: | Inpatient 2 E | R/Outpatien | t 3 DOA | Oth | | | | lence 6 Oth | os (Consih | | |
| erel d | | 27. Manner of Deat | | 28a. Date | e of tnjury 2 | 8b. Time of | | . Injui | | - | | ow tnjury occur | | " | |
| a fun | atio | 1 Natural 2 Accident | 5 Pending Investige | | nth, Day Year) | Injury | М | | Yes 2 □ N | No | | | | | |
| octor: A by the f | Certification: | 3 ☐ Suicide 4 ☐ Homicide | 6 Coutd no determin | ed 208. Plac | e of Injury - At hon | ne, farm, str | eet, factory, | office | | 28 | f. Location (S | treet and Numl | ber or Rura | / Route A | /um <i>ber</i> , |
| o di De | Cer | 4 LI HOMEGO | | Dulk | ding, etc. (Specify) | | | | | | City or Tou | ni, Siate) | | | |
| within 24 hours after dee To the Funeral Director completely filled in by the | Medicai | 29a. Certifier (Check only one) | Certifying 2 Medicat Ex | caminer: On the | e best of my knowledge best of examination of examination of examinations of e | edge, death on and/or inv | occurred at restigation, In | the tir | ne, date and pinion, deat | d place, end h occurred | d due to the d at the time, d | cause(s) and made, | anner as si and due to | ated. the caus | e(s) |
| Toth | Me | 29b. Signatura and | title of certifiar | | | | 29c. | Licens | e nu <i>m</i> ber | | | 29d. Data signe | d (Month, | Day, Yea | r) |
| | | 1/2 | In liv |) 0 | Wels : | | | ~. | 1000 |) - T | 0-022- | C = 0= | | | 199- |
| 1 | | 30. Neme and addr | ress of person w | no completed car | ISE of death (Item 3 | 23e) (Tune | Print) S | 70 | 10030 | 11-71 | 5 7338 | SEPT | EMB | ER - | 1117 |
| V) | | 30. Neme and addr | R Ra | EDC MA | A | RA | T1 44 | NA | 1 10 | SPITA | 1010 | 3 N T T | 31 0 | ELVE | DEKE |
| Sta | e | 31. Date filed (Mon | th, Day, Year) | 324 | Registrer's Signatu | 19 | - IIM | 1.7 | 1 /01 | AKY | LANO | 916 | ×15 | | |
| Registra | - | | 0 8 199 | 7 Ju | Registrer's Signatu | -Pande | 00_ | | | | | | | | |

| hua Sull | .iva | | State of Maryland | | tificate of | | | Rag. No. | 1 6 | . 1001 | | |
|--|----------------|---|--|--------------------------------|---|--------------------------------------|--|-----------------------------------|-------------|--|--|--|
| Physic | ian | Decedent's Name (First, Middle, L | =131 == | | | | 2. Date of Dea Month | | Year | 3. Time of Death | | |
| /Medi | cal | JOSHUA MATTI | | | | th Cib. Tour | June 2 | | 997 | 1:45 AM | | |
| Exami | ner | 4e. Fecility Name (If not institution, g. Mount Washington | | nital | (| Baltimo | | 4c. County | | | | |
| Funeral | | | Sex 7. Age (In yrs. It | | If Under 1 Year | If Under 24 H | | | timor | | | |
| Director | | 214-35-3219 | 1⊠M 2□ F | Yrs. | Months Days | Hours M | Irs. 8. Date of Birth (Month, Day Jan 19, | 1992 | Mary | lace (State or Foreig try) l and | | |
| 2 . | 1 | Usual Residence of Decedent | T | | | | | | | | | |
| anyta show sd.at | ۱ ا | 10a. State 10b. County | 10c. City | , Town or Lo | cation | | | | 1 | 0d. Inside City Limit: 1 ☐ Yes 2 ☑ No | | |
| in the Maryland or 28a-f show is notified at | Director | Maryland Baltime | ore | Towson | 104 Zin Ondo | | | | 170 | | | |
| th with | | | | | 10f. Zip Code | , | | 10g. Citizen of V | vnat Coun | try? | | |
| Joseph The 22 | Funeral | 101 Swarthmore | e Dr. 12. Was Decedent Ever in U.S | S. 13. V | 21204 Vas Decedent of H | | (Specify Yes or No- | USA 14. Rac | e - Americ | an indian. | | |
| | | 1 ☑ Never Married 2 ☐ Married | Armed Forces? 1 ☐ Yes 2 ☒ No | - 11 | Yes, specify Cubs | in, Mexican, Pu | erto Rican, etc.) | Blac | k, White, | | | |
| ALL | 1 by | 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give Year or Dates: | ' | ☐ Yes 2⊠ No | Specify: | | Specify | Whi | te | | |
| AAS A | Completed | 15. Decedent's E (Specify only highest g | | (Give) | ent's Usual Occup | during most of w | vorking | 16b. Kind of Bu | usiness/Ind | lustry | | |
| 1 | mp | Elementary/Secondary (0-12) | College (1-4or 5+) | | O NOT use retired | 1) | | | 4 - | | | |
| offied officer officer the | ပိ | N/A 17. Father's Name (First, Middle, Las | N/A | N/A | T | 18. Mother's N | lame (First, Middle, | | /A | | | |
| 最 も 日 中 を | To Be | Richard Sulliva | an | | | | ne Simms | | 1 | | | |
| 2 should and Mer is marks sumatic | - | 19a. Informant's Name/Relationship | | 19b. Mailin | g Address (Street | | or or Rural Route Number, City or Town, State, Zip Code) | | | | | |
| and 2 is eaith ar n 27 is ner trau | | M/M Richard Sull: | ivan (Parents) | 101 | Swarthmon | re Dr. | Towson, | MD 2 | 1204 | | | |
| 0 - E E E | | 20a. Method of Disposition | 20b. Pl | ace of Dispos | sition (Neme of atory or other place | | Date | 20c. Location - | | wn, State | | |
| nit. Page antment o ortant: If Injury or | | 1 ☑ Burlel 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec | | e View | Memoria | 1 Park | 7-1-97 | Svkesvi | 116. | Maryland | | |
| parmit. Pa Department Important: any Injury 9558 | | 21. Signature of Funeral Service Lice | ensee | 22. | Name and Addres | ss of Facility | ral Direc | | | rar y rand | | |
| 20298 | | John V- F | ty notes | - | | | Randalls | | | 1133 | | |
| | | 23a. Part). Enter the disease, or conshock, or heart failure. List only | mplications that caused the deeth | . Do not ente | r the mode of dyin | ig, such es cerd | lac or respiratory ar | rest, | | Approximate intervel Between | | |
| Physician | | | Complication | ns of (| Central N | Vervous | System Ir | niurv | | Onset end Death | | |
| /Medical Examiner | н | Immediate Ceuse (Final disease or condition resulting in death) | a (Seizure dis | sorder | and Anox | kic brai | in injury |) | | | | |
| ill.tre | Į. | , | | as a consequ | | | | | | | | |
| uted ansit | Examiner | | Shaken baby | | | | | | 1 | | | |
| be executed sician end burial-transit | Еха | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or | es e consequ | Jence ot): | | | | | | | |
| cata be executed physician end the buriel-transi | dical | Ceuse (Disease or injury that initiated events resulting in death) Last | c Due to (or | es a consequ | ience of): | | | | | | | |
| | 0 | resulting in death) Last | | | ŕ | | | | i | | | |
| eath certific ettending p | an | | d | | | | | | | | | |
| requires that the death certifications is a detected for use as the detected for use as | Physician/M | Part li. Other significant conditions | contributing to death but not resul | lting In the un | derlylng cause giv | en in Pert i. | 23b. Did to | obacco use co | ntribute to | the cause of death | | |
| that the ed by detec | | | | | | | 1□1 | es 2 No | 3 Prot | ably 4 Unknow | | |
| signed of be de | d by | | | | | | 24e. Wes a | no autonou | 24h Wa | re autopsy findings | | |
| vicion: The law requires the certificate hes been signed rector, page 2 should be | Completed | | | | | | perfor | | 976 | npletion of cause | | |
| The law ate hes b page 2 sl | dmo | | | | | | | . 87 | | deeth? | | |
| ician: Th | | 25. Was case referred to medical | | | | 00 51 | 1 V | | 1 L | Yes 2 No | | |
| Physician: rthis certific and director, | o Be | examiner? | Hospital: 1X Inpatient 2 □ E | ER/Outpetient | 3□ DOA Oth | or: | Deeth (Check only or Home 5 ☐ Resid | | or /Small | 4) | | |
| g Phys er this neral di | - | 27. Manner of Death | 28a. Date of Injury | 28b. Time of | 28c. Injun | | 28d. Describe h | | | 7 | | |
| Attending in death. | atlo | 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation | on April 24 1992 | injury | M 1 | | Chi 1d | shaken | | | | |
| Attender de cron | tific | 3 ☐ Suicide 6 ☐ Could not l | be co. Diago division and | me, farm, stre | et, factory, office | | 28f. Location (S City or Tow | treet and Numb | er or Rura | Route Number, | | |
| | Certification: | Total Construction | at | home | | | 99 Popla | ar Ave | | sville,M | | |
| ital or Jus after | <u>a</u> | 29a Certifier 1☐ Certifying P Check and 2 Medical Exa | Maician: To the best of my know miner: On the basis of examination | vledge, death on and/or inv | occurred et the tin | ne, date and pla pinion, death oc | ce, and due to the coursed at the time. | euse(s) and ma late and place. | inner as st | eted. the cause(s) | | |
| Hospital or 14 hours after Funeral Director laty filled in the | 1 = 1 | 90 | and manner steted. | / | 29c. License | | | | | | | |
| UNISION the Hospital or Attending thin 24 hours after death. the Funeral Director: After mpletaly filled in by the fune | Medical | 20h Annature and An Annier | 1.3 |) / | ZOC. LICENS | a HALLING! | 2 | 29d. Date signer | u (MODIN, L | | | |
| Hospital 24 hours Funeral staly filled | Medic | 29b. Signature and the contifier | | クノ | 43 - 0 | CME | | lon +1- | | | | |
| To the Hospital or , within 24 hours after To the Funeral Dire completely filled in the completely filled in the complete of t | Medic | 172 | necals | 20 | | CME | S | Septembe | | | | |
| To the Hospital or within 24 hours after To the Funeral Direction of the Completely filled in the Complete of | Medic | 172 | completed cause of deeth (Item | | | | | Septembe Balto | er 4, | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

27008

| | | | | | | | Cert | ificate of | f Death | | Reg. No. | | 21000 | | |
|--|---------------------------------|----------------|---|---------------------------|--------------------------------------|-----------------------|---|------------------------------------|---------------------------------------|--|---------------|-------------------------------|--|--|--|
| | hysici | an | Decedent's Name (First, Michael Control of the | idle, Last) | | | | | | 2. Date of I | Death Day | Year | 3. Time of Death | | |
| | /Medic | | Lilli | an D. Sp | erber | | | | | 00 | | 6 97 | 135 | | |
| | xamin | | 4a. Facility Name (If not institu | | | | | | | or Location of De | ath 4c. | County of Deal | | | |
| | | | Westminste | | | | | | Westmi | | | Carro | 11 | | |
| | neral ector | | 5. Social Security Number 212–34–4261 | 6. Sex 1 □ M 2 | | n yrs. last biri | thday)_ Yrs. | Months Day | | in. 8. Date of in. (Month, July | Day, Year) | 9. Bir | thplace (State or Foreign buntry) yland | | |
| Pu | * | | Usual Residence of Decedent 10a. State 10b. Cour | h | 10 | Oc. City, Towr | 2 05 1 000 | ation | | | | | | | |
| aryle | Show and at | 5 | | timore | | Reiste | | | | | | | 10d. Inside City Limits 1 ☐ Yes 2 No | | |
| the | notified | Director | 10e. Street and Number | 02.11.02.0 | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | | | | | |
| th with | MI De | rai Dir | 45 Green | view Ave | • | | | 10f. Zip Code 211 | | | 10g. Citiz | U.S.A | | | |
| ar da | Def La | Funerai | 11. Marital Status | Arm | s Decedent Eve ned Forces? | er in U,S. | 13. W | as Decedent of Yes, specify Cu | Hispanic Origin? ban, Mexican, Pu | (Specify Yes or I erto Rican, etc.) | No- 1 | 14. Race - Ame Black, Whit | | | |
| 21215-0020 d within 72 hours after giena. | à E | þ | 1 Never Married 2 M 3 Widowed 4 Divorc | If Ye | Yes 2 No es, Give ar or Dates: | | | ☐ Yes 20(No | | | | | ite | | |
| 5-(| odical Ex | etec | 15. Deced (Specify only high | ent's Education | leted) | 18a. | Decede (Give ki | nt's Usual Occi | upation e duning most of v red) | vorkina | 16b. Kir | nd of Business/ | findustry | | |
| within ena. | | Be Completed | Elementary/Secondary (0-12 | T | lege (1-4or 5+) | | | | | | Н | memake | m | | |
| d 2 | F, | ပိ | 12 17. Father's Name (First, Middle | a (ast) | | | Ho | usewife | | lame (First, Mida | | | 1 | | |
| Maryland 212 d2 should be filed within th and Mental Hygiena. | 8 A B D | To Be | | ert Diet | zel | | | | | Huffmar | | sumame) | | | |
| and M | | F | 19a. Informant's Name/Relatio | nship <i>(Type, Pri</i> n | nt) | 19b. | Mailing | Address (Stree | et and Number or | | | Town State | Zin Code) | | |
| = D € N | or other traumatic evant, the M | | Kenneth S | | ., | 5 | 617 | Mews D | r., Owin | gs Mills | s, Md. | 21117 | LIP COOR | | |
| of He | ę l | | 20a. Method of Disposition 1 □ Burial 2 □ Cremation | ٥٦٥ | 4. 0. | 20b. Place of cemeter | Disposi | tion (Name of story or other pl | lace) | Date | 20c. Loc | cation - City or | Town, State | | |
| Pag nent | ý | | 4 Donation 5 Other | | from State | | | | y Sept. | 9,1997 | Bal | timore, | Md. | | |
| Baltimore, | any Injury once. | | 21. Signature of Fynesal Service | e Licensee | .1 | | 22.1 | Name and Add | ress of Facility | | | | 21117 | | |
| m 881 | 6 8 | | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills | | | | | | | | | | | | |
| - | | | 23a. Part1. Enter the disease, shock, or heart failure. Li | or complications | that caused the | death. Do n | ot enter | the mode of dy | ing, such as card | iac or respiratory | arrest, | go mirri | Approximate | | |
| Physi | Ician | 1 | 57750K, 57 11441 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | or only one cause | A | | | | | | | - 1 | Interval Between Onset and Death | | |
| | dical | | Immediate Ceuse (Final disease or condition resulting in death) | | Tuna 1 | Cmar | ۸. | | | | | 1 | Im. | | |
| Exam | | | resulting in death) | a. | Oue | e to (or as a c | onseque | enca of): | | | | | 110 | | |
| 2 | sit | ine. | | | Mid | tenle | m | nelon | M. | | | | 25 m | | |
| and and | -tran | Examiner | Sequentially list conditions, if any leading to immediate | | Due | e to (or es a c | onseque | or (de of): | | | | | | | |
| 68760, ificata be ass | a as the bunal-transit | E I | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events | ? c | | | | | | | | | | | |
| 587 icata | s the | edicai | resulting in death) Last | 1 | Due | to (or as a co | onseque | nce of): | | | | | | | |
| , P.O. Box 68760, that the death certificate be executed ed by the attending physician and | 8 8 | ≥ | | d | | | | | | | | | - | | |
| Boy attendi | for | Ciai | Dod II Other deallings and a self | | | | | | | | | | | | |
| P.O. | datached for usa | Physician/ | Part II. Other significant condi | ions contributing | to death but no | ot resulting in | the und | erlying cause g | iven In Part I. | | | | to the cause of death? | | |
| That | d be date | by P | | | | | | | | 1 | Yes A | No 3□Pi | robably 4 Unknown | | |
| rds pulres | pi pi | 쭚 | | | | • | | | | 24a. Wa | is an autops | sv 24b. | Were autopsy findings | | |
| Records, ha law requires to has been signed a has been signed. | should | Completed | | | | | | | | per | formed? | | available prior to completion of cause of death? | | |
| I Red The law | age 2 | E O | | | | | | | | | 1V 08 | | . / | | |
| | rector, paga | Be C | 25. Was case referred to medic | al | | | | | Of Diago of D | | 7.77 | No | 1 ☐ Yes 2 No | | |
| of Vita Physician: this certific | direct | 2 | examiner? 1 Yes 2 No | Hospitel: | 1 Inpatient | 2 ER/Out | nationt | 3 DOA O | ther L. | eath (Check only Home 5 Re | | □Othor (Coo | -25.1 | | |
| Phys ar this | | | 27. Manner of Death | | Date of Injury | 28b. Ti | ime of | 28c. Inje | | 28d. Describe | | | энуу | | |
| Vision Attending order: Afte | the funaral | atio | 1 Netural 5 Pend 2 Accident inves | ing tigation | (Month, Day Ye | ear) in | jury | | ork?]Yes 2 ☐ No | | | | | | |
| Division or Attending Fatter death. Director: Atter | in by th | 100 | 3 Suicide 6 □ Could | mined 200. | Placa of Injury | At home, fer | m, stree | t, factory, office | , | | | Number or Ru | iral Route Number, | | |
| Die safte | ni De | Certification: | 4 🗆 Homicide | | bullding, etc. (S | респу) | | | | City or 1 | own, State) | | | | |
| To the Hospital within 24 hours To the Funeral I | completely filled | | 29a. Certifier 1 Certify | ing Physician: T | o the best of my | y knowledge, | death o | ccurred at the t | ime, date and ple | ce, end due to th | e cause(s) a | and manner as | stated. | | |
| he H | plata | edicai | one) 2 Medica | and | manner stated. | mination and | or Inves | stigation, in my | opinion, death oc | curred at the time | e, dete and p | place, and due | to the cause(s) | | |
| To the within 2 | Com | | 29b. Signature and title of certif | er N | | | | 29c. Licen | se number | | 29d. Date | signed (Montt | h, Day, Year) | | |
| | | | 1 com | Shed | 00-1 | | | 172 | 544 | Σ | 9 | 100 | 7 | | |
| 7 | 1. | | 30. Name and address of perso | who completed | cause of death | (Item 23a) (1 | Гуре, Рг | Int) | 7/13 | | ~ | - WIT | 1 | | |
| 71 | | | 688 Por | 4 Koo | of In | estr | m | ster | and | 2115 | + | | | | |
| | Stat | - | 31. Date filed (Month) Day, Yea |) | 32. Registrar's | Signature | | 6 | | | - | | | | |
| Re | egistra | r | OFD 0 0 400 | | P. K. | | | | | | | | | | |
| DHMH 16 R | lev 6/95 | | SEP 0 8 199 | 1 9 | wha David | son-Aano | delle | | | | | | | | |

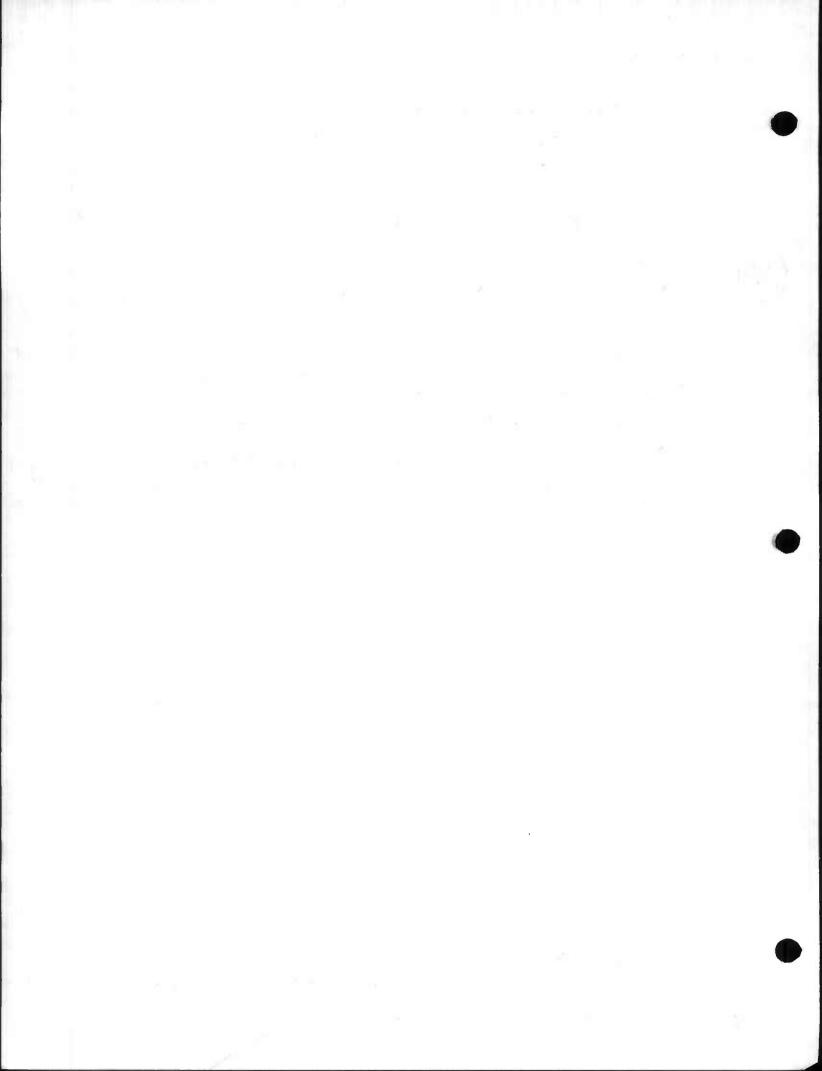
g . 11 co assertation activities and earlier extra Asserta c /= _____ Title .of , if the course, ,ere and ETT | welfore course a

| | | | | | Certificate of | | Reg. No. | 1 21009 |
|-------------------|--|------------------|---|--|--|--|-------------------------|--|
| ı | Physic | | Decedent's Neme (First, Middle, Last HARRIETT | # HENRIETTA | TAYLOR | 2. Dete of D Month AUGUST | Dey | Year 997 2:12 AM |
| | /Medi Exami | | 4e. Facility Neme (If not institution, give 828 NORTH FULTON | street end number) | | 4b. City, Town, or Location of Dec | th 4c. County | |
| | Funeral Director | | 2.0 .2 01.0 | | 4 Yrs. If Under 1 Year Months Deys | Hours Min. SEPT. | 7, 1922 | 9. Birthplece (State or Foreign MARYLAND |
| | aryland show d.at | _ | Usuei Residence of Decedent 10e. Stete 10b. County | | , Town or Location | | | 10d. Inside City Limits |
| | with the Marylan a or 28a-f show be notified at | Director | MARYLAND 1 10e. Street and Number | IIA | BALT 10f. Zip Code | THORE CITY | 10g. Citizen of V | 1 1 1 Yes 2 □ No What Country? |
| | beth w | eral [| 828 N. FULT | ON AVENUE 12. Was Decedent Ever In U. | | 21217 | | S A . |
| 50 | Samon Samon | by Funeral | 11. Meritel Stetus 1 □ Never Merried 2 □ Married 3 🕱 Widowed 4 □ Divorced | Armed Forces? 1 Tyes 2 X No if Yes, Give Year or Detes: | 13. Was Decedent of P | dispenic Origin? (Specify Yes or Nen, Mexican, Puerto Rican, etc.) Specify: | | ck, White, etc. |
| 5-6 | | | 15. Decedent's Ed (Specify only highest gra | ucation | 16e. Decedent's Usuel Occup | pation during most of working | 16b. Kind of Bu | usiness/Industry |
| 2121 | | Completed | Elementery/Secondery (0-12) 12+HGRADE | College (1-4or 5+) | (Give kind of work done life. DO NOT use retire | | BAITA | URBAN LEAGU |
| B | al Hyg al Hyg I other veent, | BeC | 17. Fether's Neme (First, Middle, Last) | | C 13-741 C | 18. Mother's Neme (First, Middle | | |
| Marylan | d Ment d Ment marks marks | To | CHARLES 19e. informent's Neme/Relationship (7) | | AWKINS | LENA U | _ | RISCOE |
| _ | other treu | | ADRIENNE WILSO 20e. Method of Disposition | N (DAUGHTER) | 728 N. FULTO lieca of Disposition (Name of ametery, cremetory or other ple | N AVE. BALTIL | ORE MA |). 2/2/7 City or Town, State |
| Baltimore | Page ment of ant: H jury or | | 1 Buriei 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Specify | Hemovel from State | TIMORE NATIO | 0 5 6 6 | BALT | HORE, MARYLAN |
| Bai | Depart Import any in | | 21. Signeture of Funerei Service Licen | o, Q 1- | JOSEPH H. | BROWN JR. FUNE | | |
| | | | 23a. Pert1. Enter the disease, or comp shock, or heart feilure. List only | ilcetions that caused the death | 2140 N. F | ULTON AVENUE, B | ALTIMORE arrest, | Approximete |
| | Physician /Medical Examiner | | trimmediate Cause (Final disease or condition resulting in death) | Arterio | scleroto | Cardion | asc | Interval Between Onset and Deeth |
| | | ner | | Due to (or | r as a consequence of): | 1400416 | 0 | 3 yrs |
| | ficate be executed physician and is the burial-transit | Examiner | Sequentially list conditions, if any, leeding to immediate | Due to (or | as a consequence of): | 1=1=000 | | |
| 68760, | ate be anysiciar | edicail | cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest | c. Due to (or | es e consequence of): | | | i |
| | death certification attending pl | | L. | d | | | - | 1 |
| Box | e death certification the attending the discussion is a second to the second in the se | Physician/M | Pag II. Other significant conditions co | ntributing to death but not resu | alting in the underlying cause gh | ven in Part I. a. 23b. Die | d tobacco uas co | ntribute to the causs of death? |
| s, P.O | that the ed by detac | by Phy | Carcenon | lo a | the T | | Yes 2□No | 3 □ Probably 4 Donknown |
| of Vital Records, | e law requires has been sign ge 2 should be | Completed | | | | 24a. Wa | s an autopsy formed? | 24b. Were autopsy findings available prior to completion of cause of death? |
| al R | The ata h | | | | | 10 | Yes 20 No | 1 ☐ Yes 2 No |
| Vit | Physician: The this certificata ral director, par | o Be | 25. Wes case referred to medical exemples? 1 2 Yes 2 No | Hospitai: 1 ☐ inpatient 2 ☐ I | ER/Outpatient 3□ DOA Oth | 28. Place of Death (Check only | | ner (Specify) |
| | p te | Certification: T | 27. Manner of Death Neturai 5 ☐ Pending | | 28b. Time of injury Wo | | how injury occur | |
| Division | the fact | | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined | 28e. Piece of Injury - At ho building, etc. (Specify | me, ferm, street, fectory, office | Yes 2 No 28f. Location City or To | (Street and Numb | per or Rural Route Number, |
| ۵ | To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fo | edical Ce | 29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam | sician: To the best of my know | viedge, deeth occurred at the til | me, date and piace, end due to the | e ceuse(s) end ma | anner as stated. |
| | o the l | Med | one) 29b. Signature and title of certifies | and menner stated. | 29c. Licens | | | d (Month, Day, Year) |
| D | F>F0 |) | Chresh | show | T prior | 32263 | 9/5 | 197 |
| | 0 | | 30. Neme end address of person who d | ompleted cause of death (Item | 23a) (Type, Print) | DE ST T | WITIA | 100E M |
| | Sta | te | 31. Dete filed (Month, Day, Year) | 32. Registrer's Signet | ure | | Mr. II | INTE INT |

State Registrar

SEP 0 8 1997

antima property and . 1 1 = 1 ---aller and the figure of and the second of the second o Les di upp gormando pelalimente l'Eleman primenano ne unito avegno pli



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Deta of Death

show

Baltimore, Maryland 21215-0020

Physician /Medical **Examiner**

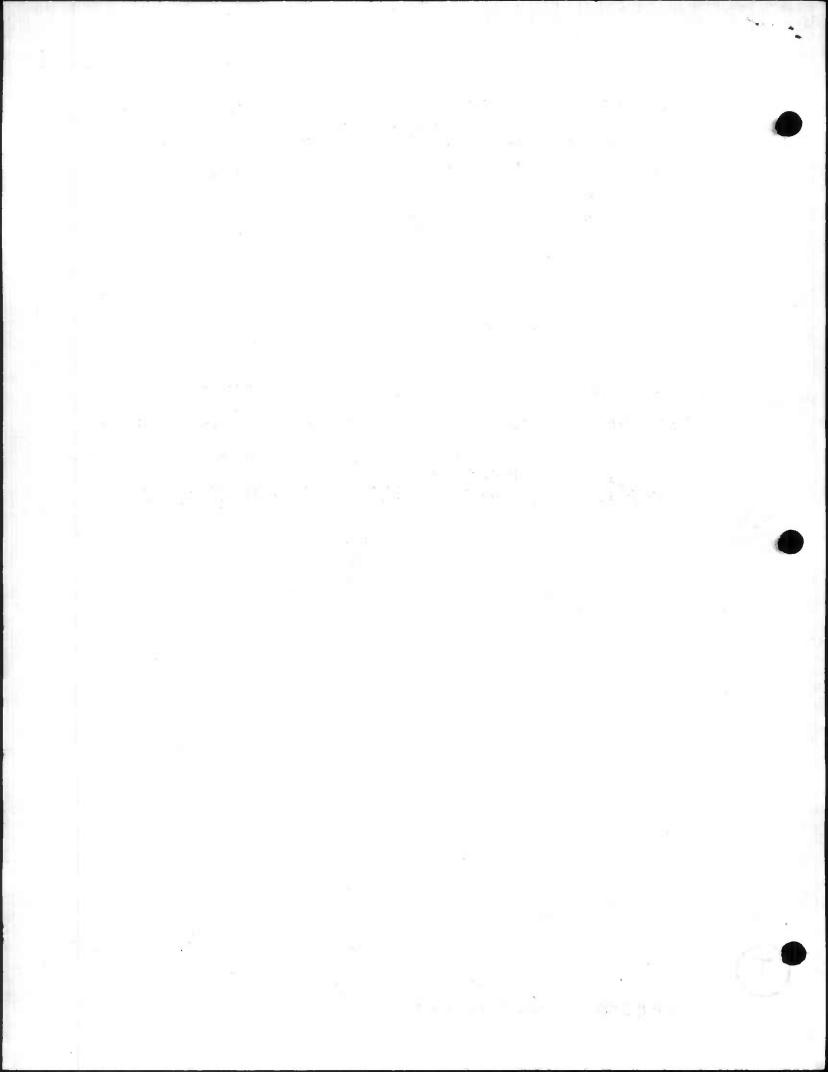
I or Attending Physician: The law requires that the death certificeta be executed after death.

Director: After this certificate has been signed by the attending physician end in by the inverted inector, page 2 should be datached for use as the burial-transit of in by the inverted inector, page 2 should be datached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Registrar

1. Decedant's Nama (First, Middla, Last) 3. Time of Death Month **Physician** Ame lia Tacka Sertember 5:00 Am /Medical 4a. Facility Nama (If not institution, giva straat and number) 707 Maiden Choice Ln. 4b. City, Town, or Location of Daath **Examiner** 4c. County of Death Charlestown Retirement Community Apt. #8109 Baltimore Catonsville If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year)

June 29, 19 7. Aga (In yrs. last birthday) 5. Social Sacurity Number 9. Birthplaca (State or Foreign Country)
Maryland **Funeral** Months Days 1 □ M 2 🗙 F 216-12-6139 Director 85 1912 Usual Residence of Decadent 10a State 10b. County 10c. City, Town or Location 10d. fnsida City Limits Peges 1 end 2 should be filed within 72 hours aftar death with the Marylar nent of Health and Mental Hygiena. ant: If Item 27 is merked other than "natural", or Items 23a or 28a-f show ary or other traumatic event, the Medical Examines must be notified. **Funeral Director** 1X Yes 2 □ No Maryland N/A Baltimore 10e. Streat and Number 10f. Zip Code 10g. Citizan of Whet Country? 2216 Pelham Avenue 21213 United States 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ②No If Yas, Giva Yaar or Datas: 11. Maritel Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Ricen, etc.) 14. Raca - American Indien, Black, Whita, atc. 1 Never Married 2 Marriad 1 ☐ Yas 2 🖾 No Specify: by Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decadant's Education 16b. Kind of Business/Industry (Specify only highast grada completed) Elementary/Secondery (0-12) College (1-4or 5+) 12 Clerk Typist Real Estate 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Surname) Be Vincent Tacka Bessie Welzant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) Theresa Creamer / Sister Lutherville, MD 21093 1113 Longbrook Road 20b. Plece of Disposition (Nama of cematary, cramatory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cramation 3 ☐ Ramoval from State permit. Pege Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) St. Stanislaus Cemetery 9/9/97 Dundalk, Maryland 21. Signature of Funaral Service Licensea | Timothy S. Harman | 22. Nama and Address of Facility Leonard J. Ruck, Inc. Funeral Home 5305 Harford Road Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata Interval Batween Onsat and Death Immedieta Cause (Finel diseesa or condition resulting in daath) Myo cardial In Sarction Due to (or as a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or Injury that initiated avents rasulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown þ Completed 24b. Wara autopsy findings 24a. Was an autopsy available prior to completion of ceuse of deeth? performed' 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa referred to medical axaminer? Be 26. Pleca of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 524 Rasidence 6 Othar (Specify) Certification: To 1 Yas 2 No 27. Manner of Death 28e. Deta of Injury (Month, Day Year) 28d. Describe how Injury occurred 28c. Injury et Work? 1 Natural 2 Accident 5 Pending invastigation 1 Yas 2 No 3 ☐ Suicide 6 Could not be datermined 28a. Pleca of Injury - At homa, farm, straet, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicida Hospital 24 hours 24 hours edicai 12 Certifying Physician: To the bast of my knowladga, daath occurred et tha tima, data and place, end due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basts of examination end/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mennar stated. 29a. Cartifier To the Hosp within 24 ho To the Fune completely fi (Check only one) Σ 29b. Signetura and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 5 1997 047447 30. Name and address of person who completed causa of deeth (Item 23e) (Type, Print) Maryland Maiden Choice atons villo Lane 32. Registrer's Signatura 31. Dete filed (Month, Dey, Year) State SEP 0 8 1997



| | | | State of Marylar | Certificate of Death | | eg. No. | 2/012 |
|-------------------|--|-------------------------|---|---|--|---|--|
| | Physic | | 1. Decedent's Neme (First, Middle, Last) FRANK UCHACZ | | 2. Dele of Deet | th Day 7 Yaar 199 | 3. Tima of Deeth |
| | /Medi Examii Funeral Director | | 4a. Fecility Neme (If not institution, give street end number) HOSPICE OF Baltmore - G 5. Societ Sacurity Number 6. Sax 7. Age (In yrs. 109-07-9925 Usuel Residence of Decedent | ilchrist Center Baly | wn, or Location of Death | Baltima | |
| | the Maryland 28a-f show | or | 10a. Stele 10b. County 10c. Cit | ty, Town or Location | | | 10d. Inside City Limiis 1 ☐ Yes 2KXNo |
| | h with the I | al Director | 10e. Street and Number 3351 North Chatham Road; Apt. | 10f. Zlp Code E 21042 | 1 | 0g. Citizen of Whai Cou | untry? |
| 020 | 72 hours after death with the Marylend natural; or items 23s or 28s-f show deal Examiner pust be notified at | by Funeral | 11. Maritel Status 12. Wes Decedent Ever in U Armed Forcas? 1 Never Married 2 Married 1 Yas 2 No If Yes, Give Yaer or Detes: | | gin? (Specify Yas or No- , Puerto Rican, atc.) | 14. Race - Amar Black, White Specify: whi | e, etc. |
| 21215-0020 | C | Completed | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) 12 College (1-4or 5+) | 16a. Decedent's Usuel Occupation (Give kind of work done during most life. DO NOT use retired) Self employed | of working | 16b. Kind of Business/ | |
| Maryland ; | should be filed with end Mental Hygiene. Is marked other than aumatic event, the M | To Be C | 17. Fether's Neme (First, Middle, Last) Sam Uchacz | 18. Mothe | r's Name (First, Middle, A Cherine Gore | Melden Surneme) | Owner |
| | end 2 sho saith end N n 27 Is ma | | 19e. Informent's Neme/Reletionship (Type, Print) Mr. Ron Uchacz/son | 19b. Mailing Address (Street and Number 10510 Hunters Way, | | | |
| altimore, | 00- | | 20e. Method of Disposition 1 Buriel 2 Incrementation 3 Removed from State 4 Donetion 5 Other (Specify) | Laurel, | | | |
| Balt | permit. Peg Department Important: It any Injury o | | 21. Signeture of Funerel Service Licensae | 22. Name end Addrass of Facility Slack Funeral Ellicott City | Home, P.A. | 21043 | |
| The second | Physician /Medical Examiner | er | Pert1. Enter the disease, or complications that caused the deat shock, or heart fellure. List only one cause on each line. | h. Do not enter the mode of dying, such es of the Cardiomyop or es e consequence of): | | >st, | Approximata Intervel Between Onsat and Death |
| Box 68760, | sath certificete be executed etherding physician end for use as the buriel-transit | an/Medical Examiner | if eny, leeding to Immediate causa. Enter Underlying Couse (Disease or Injury | or es e consequence of): or es e consequenca of): | | | |
| s, P.O. | ss that the degree by the be deteched | by Physician/M | Pert II. Other significant conditions contributing to death but not res Right Homispheric | | | | to the cause of death? |
| Record | hes b | Completed | | | 24a. Wes ei perform | ned? | Were autopsy findings available prior to completion of cause of death? |
| Division of Vital | Attending Physician: The strength of the stren | Certification: To Be Co | 27. Menner of Deeth 1 Neturel 5 Pending (Month, Day Year) 2 Accident investigation 3 Subside 6 Could not be | ER/Outpetient 3 DOA Other: 4 Nur 28b. Time of Injury Mork? M 28c. Injury et Work? 1 Yes 2 N Ome, ferm, street, factory, office | of Death (Check only on rsing Homa 5 Raside 28d. Describe ho | e) since 6 Other (Spec w Injury occurred | |
| ۵ | To the Hospital or within 24 hours effer Yo the Funeral Dir completely filled in | edical Ce | 29a. Certifier (Check only one) CertifyIng Physician: To the best of my kno 2 Madical Examiner: On the basis of exemine end menner steted. | wledge, deeth occurred et the time, dete end tion and/or Investigation, In my opinion, deet | d plece, end due to the ce th occurred et the time, da | ouse(s) end manner as ate end plece, end due | steted. to the ceuse(s) |
| 1 | To the within to the comp | Me | 296. Signature and vito of certifier the strong full | 29c. License number DDSDOS | | extender 5 | |
| | Sta | 10 | 30. Neme and eddress of person who complete cause of death (Neg | 23a) (Type, Print) 201 N-Charles St | . BAlto. | My 212 | 04 |
| | Registr | 16.1 | APT O D 1991 | Production of the second | | | |



State of Maryland / Department of Health and Mental Hygiene 27013 Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3. Time of Deeth WAITT Month Dey SEPTEMBER OT **Physician** WALTER 7:17 AM /Medicai 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner HOSPITAL RANDALLS TOWN BALTIMORE NORTH WEST If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 157M 2□ F Months Days 87 Yrs. 279-18-0237 Ohio Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1√ Yes 2 No Director Lorain County 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4850 Pheasant Drive, Lorain, OH 44053 44053 USA Funeral 11. Maritel Status 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indien, Black, White, etc. 1 Yes 2 No
If Yes, Give
Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specity: þ Specify: 3 Widowed 4 □ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondery (0-12) Retail Photo Shop 12 yrs Photo Engraver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Waitt, Sr. Elsie Marian Waitt To Walter 19a. informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 3415 Fallstaff Road, Baltimore, Maryland 21215 Mr. Gary Waitt 20b. Plece of Disposition (Name of cometery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 9/9/97 Baltimore, Maryland Green Mount Crematory 21. Signature of Funeral Service Lynsee

Martin 22. Name end Address of Fecility Mitchell-Wiedefeld Home 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest,

Approx Approximete Intervel Between Onset end Death Immediate Cause (Final PINEUMONIA. diseese or condition resulting in death) Due to (or es e consequence of): Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequenca of): Physician/Medical Due to (or es e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown CORONARY ARTERY DISEASS p 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed FAILURE RENAL COPD 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical Be 26. Place of Death (Check only one) exeminer? Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 27. Manner of Deeth 28a. Dete of tnjury (Month, Dey Yeer) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending Investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 | Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signature and this of certifier PHYSICIAN 29d. Dete signed (Month, Day, Year) 29c. License number HOUSE D42723. SEPTEMBER

the burial-transit Box 68760, 2 attending P.O. 2 signed t Records, page Division of Vital To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera

Funeral

Director

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ò must be Herra 23a

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and 2 × nt of Health a

permit. Page Department of Important: If any injury or

Physician /Medical

Examiner

Baltimore,

5-0020

r 25a-f show

State Registrar

HARISH Austrar's Signature Fandelle

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

VYERA HALLI

31. Dete filed (Month)

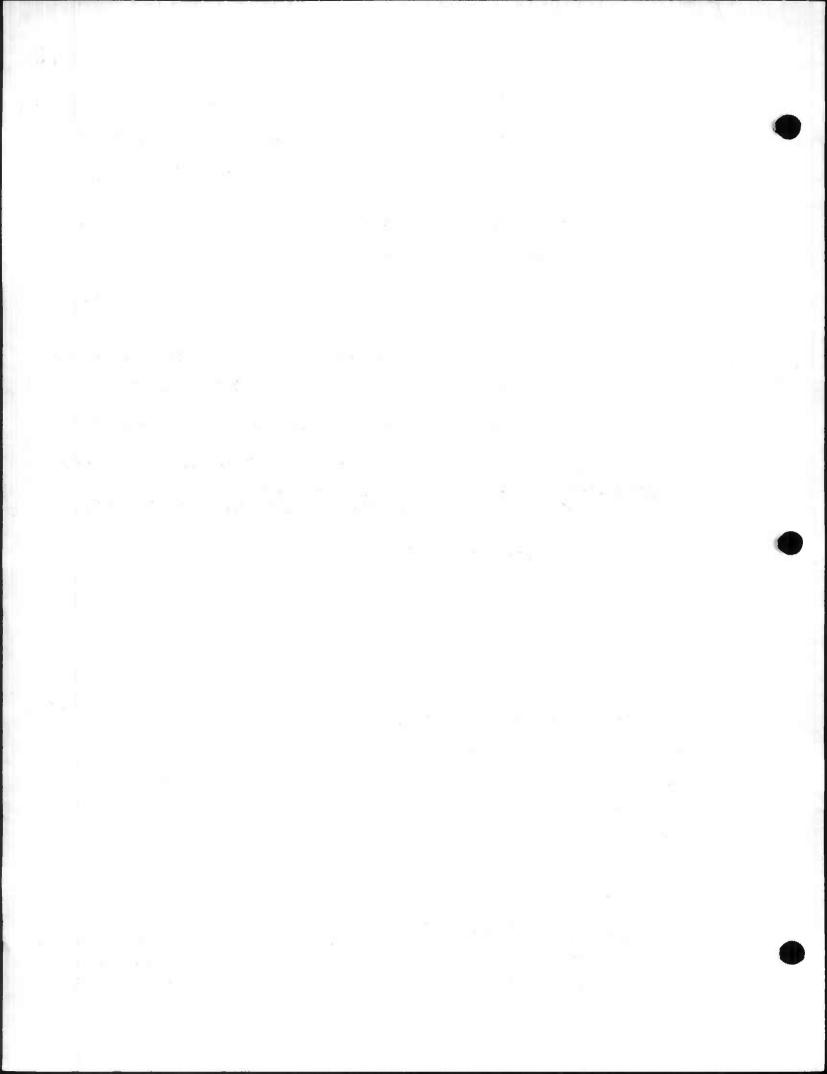
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BALTIMORE

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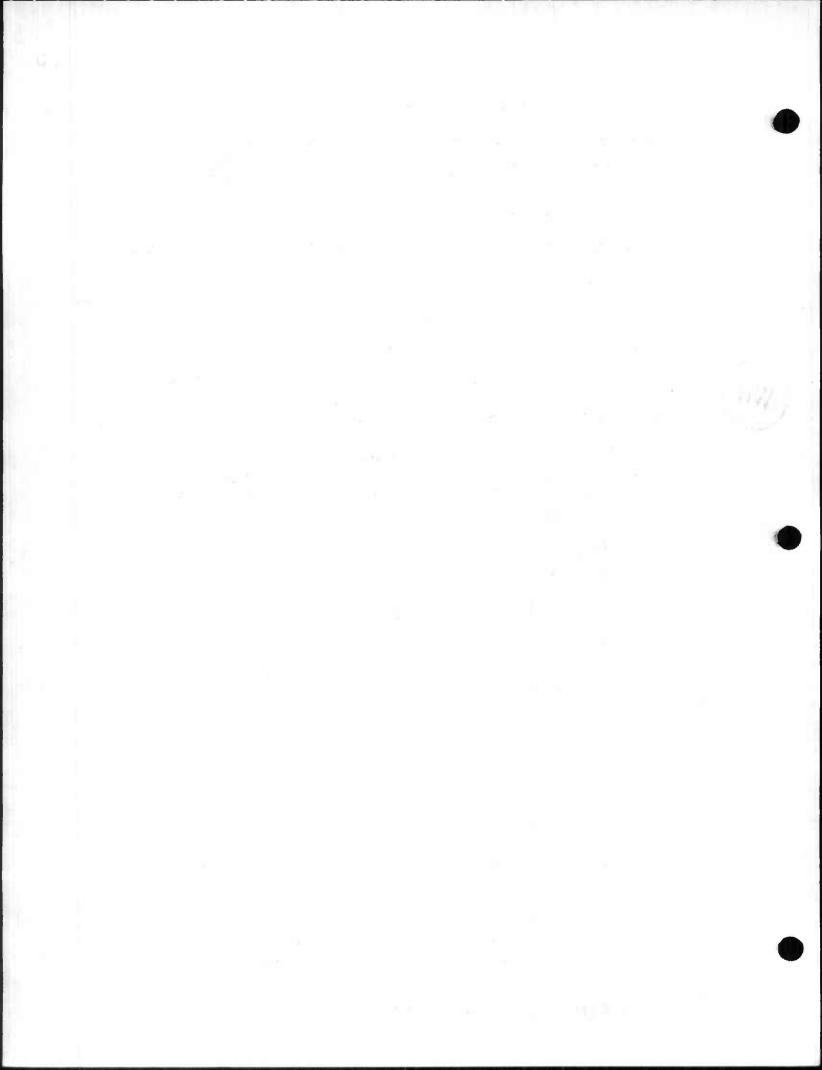
| NOX | ALD WII | LT | AMS | State of Maryland / | Department of I | Health and Mei | ntal Hygiene C | 7 27014 |
|--------------------------------|---|-------------------------------------|---|---|--|---|---|---|
| | | | part I 27 per MEO G-75 | | Certificate of | Death | Reg. No. | 1 1014 |
| ı | Physic | an | Decedent's Name (First, Middle, Las | — | | | Date of Death Month Day | 3. Time of Death |
| | /Medi Exami | cal | DONALD 4a. Facility Name (If not institution, give | EDWARD street and number) | WILLIAM | 4b. City, Town, or Locat | PTEMBER 03, ion of Death 4c. County | 1997 1850PM |
| | Funeral Director | | 5. Social Security Number 6. Se | REHABILATION C | | GLEN BURNIE If Under 24 Hrs. Hours Min. | Date of Birth (Month, Day, Year) | ARUNDEL COUNTY 9. Birthpiece (State or Foreign Country) MARY LAND |
| Baltimore, Maryland 223 9-0020 | permit. Pages I and 2 should be negotiated cours after death with the Maryland Department of Health and Mental Pages. Importants if them 27 is marked other than "natural", or have 23s or 23s-f show any injury or other traversite event, the Medical Examiner must be notified at once. | To Be Completed by Funeral Director | 10a. State 10b. County MARVLANN A.A. C. 10e. Street and Number 7 6 8 5 PEN (11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest green starty/Secondary (0-12) N.D. GRADE 17. Father's Name (First, Middle, Last) EDWARD 19a. Informant's Name/Reletionship (7) DOROTHY WILLIA 20a. Method of Disposition 1 Name of Disposition 20a. Method of Disposition 21a. Signature of Funeral Servica License | CER ROAD 12. Was Decedent Ever in U.S. Armed Forces? 1 | 13. Was Decedent of I If Yes, specify Cub 1 Yes, specify Cub 1 Yes 2 No a. Decedent's Usual Occu. (Give kind of work done life. DO NOT use retire LABORER AMS b. Mailing Address (Stree. 16. 80 SPEN of Disposition (Nemo of ery, crematory or other ple 22. Name and Addr. 22. Name and Addr. 30. SEPH | A 1060 Hispanic Origin? (Specifylan, Mexican, Puerto Rice Specify: Petion during most of working rich) GROWND KEE 18. Mother's Name (F DOROT t and Number or Rurel R GER ROAD CER ROAD Ace) ETERY 9-0 pass of Facility BROW H. BROW | 10g. Citizen of U (Yes or No- an, etc.) 14. Rac Bla Specify 16b. Kind of B PER GLEN H irst, Middle, Meiden Surnan HV R outle Number, City or Town, GLEN BURN 20c. Location 7-97 GLEN UN JR. FUNE | SA Se - American Indian, ck, White, etc. BLACK usiness/Industry AVEN CEMETERY The GAITHER |
| | Physician /Medical Examiner | | 23a. Pert1. Enter the disease, or comp shock, or heart feilure. List only of Immediate Cause (Finel disease or condition resulting in death) | BRONCHOPNEUMONIA C | not entar the mode of dyi | ng, such es cardiac or re | espiratory arrest, | Approximate interval Between Onset end Death |
| - | pe is | line | | ALCOHOLISM | | | | * |
| ox 68760, | leath certificete be executed attending physician and I for use as the burial-transit | ian/Medicai Examiner | Sequentially list conditions, it any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last | C | consequence of): | | _ | |
| m. | atte | iciai | Part II. Other significant conditions co | intributing to death but not resulting | in the underlying cause of | ven in Part I | 23h Did tahacan usa co | ntribute to the cause of death? |
| P.0 | that the died by the detached | Physicia | • | | | | 1 □ Yee 2 □ No | 3 Probably 10 Inknown |
| Records, | e law requires has been sign ge 2 should be | ompleted by | | | _ | | 24a. Was an eutopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
| Vital | | O | 25. Was case referred to medical | | | OC Place of Death (C | 12 ×es 2 □ No | Yes 2□ No |
| of | ing Phys | ation: To B | examiner? | | Time of 28c. Inju | 26. Place of Death (Cher: 4 Nursing Home ry at rk?) | | REHAB ner (Specify) CENTER red |
| Division | 5 # 5 = | Certification: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Placa of Injury - At home, f building, etc. (Specify) | arm, street, fectory, office | 28f. | Location (Street end Numb City or Town, State) | ber or Rural Route Number, |
| | Hospita 24 hours Funeral | edical C | 29e. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam | rsician: To the best of my knowledginer: On the basis of examination e and manner stated. | e, death occurred at the ti | me, dete end place, and opinion, death occurred e | due to the ceuse(s) and me at the time, dete and place, | anner es stated. end due to the cause(s) |
| | To the To the comple | Me | 29b. Signature and little of certifier | 200 | 29c. Licens | se number | 29d. Date signe | d (Month, Day, Year) |
| | | | Denni | Chute no | O.C.N | 1.E. | SEPTEME | BER 04, 1997 |
| | | | Dennis J. Ch | ompleted cause of deeth (Item 23a) where more than 1 | | eet, Baltim | ore, Maryland | 1 21201 |
| | 0 | A - | 31 Date filed (Month Day Veer) | #32 Pagistrar's Cignoture | | | | |

Registrar

SEP 0 8 1997

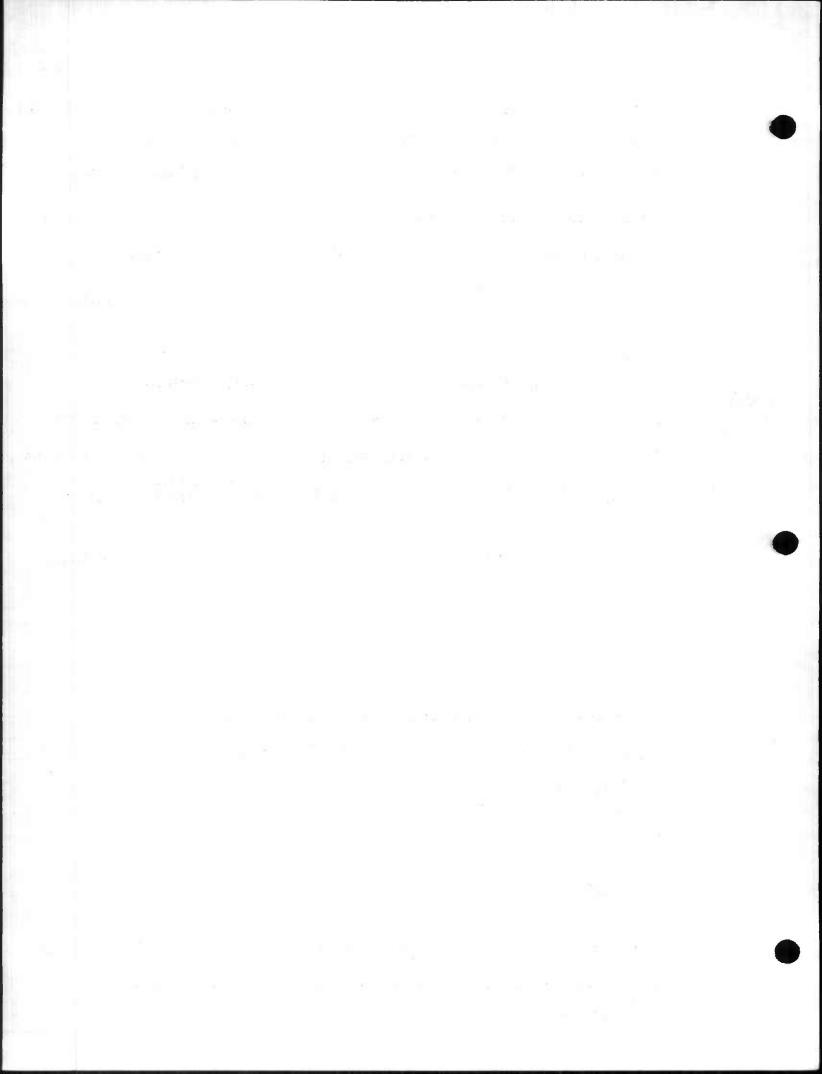
32. Registrar's Signeture

| | | Decedent's Nema (First, Middle, Le | State of IV | | Cer | tificate of | | 2. Date of D | Reg. No. | 1 21013 |
|---|------------------|--|---|---------------------------------|-------------------------------------|---|---|--|---|--|
| Physicia /Medica | al | | Melani | | Warren | | 4.02 | Month SEPT. | Day 0.4 1 | Year 997 7:55 A.M |
| Examine Funeral Director | | 220 60 9879 | Mercy Hos | pita: | lest birthdey) Yrs. | If Under 1 Year Months Deys | Baltim If Under 24 H | S. 9 Date of B | | of Deeth N/A 9. Birthplece (State or Foreign Country) Florida |
| Maryland a-f show | | Usual Residence of Decedent 10a. State 10b. County Maryland Anne Ar | rundel | | y, Town or Loc | | | | | 10d. Insida City Limita 1 ☐ Yes 2 🔀 No |
| death with the Maryland rms 23a or 28a-f show rms 12a or 28a-f show | al Director | 10e. Street and Number 114 Bon Air Road | đ | | | 10f. Zip Code 21 | 225 | | 10g. Citizan of V | |
| 5-UUZU 72 hours after death with the Maryla natural; or frems 23a or 28a-4 should be Examerer invest to notified at | by Funeral | 11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorcad | 12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Yeer or Dates: | ? [No | If | las Decedent of l Yes, specify Cub | | (Specify Yes or Norto Rican, etc.) | o- 14. Race Blec Specify | a - American Indian, k, White, etc. White |
| d within 72 hours after death with ingree. In them "netures", or frems 28a or in the Medical Examiner mant be in | Completed | 15. Decedent a E (Specify only highest gn Elementary/Secondery (0-12) 12th | ducation ade completed) College (1-4or | 5+) | | ent's Usuai Occu ind of work done O NOT use retire Maker | pation during most of w | rorking | 16b. Kind of Bu | isiness/industry |
| E E E | To Be (| 17. Fether's Name (First, Middle, Last | | odd | | | | | s, Meiden Sumem Sorenson | |
| | No. of Parties | 19a. Informant's Name/Relationship (Neil C. Warren 20a. Method of Disposition | Type, Print) / husbar | 20b. F | 114 B | on Air | Road | | | Stete, Zip Coda) and 21225 City or Town, State |
| Demil. Peges Department of important: if the any injury or or once. | | 1 ☐ Burlei 2 【MCremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specifical Services Licenters) | (y) | | emetery, cremo | ervice (Neme and Addre | Corp. | 9/5/97 | Towson | , Maryland |
| Demi Depari Import any it | | 23a. Part1. Entar tha diseasa, or com shock, or haart failure. List only | E Do | d the daet | 2 40 | 01 Ritch | nie High | way Bal | timore, | Home P.A. Md. 21225 |
| Physician /Medical Examiner | | Immediate Cause (Final disease or condition resulting in death) | | PATIC | C/ARR or es a consequ | H0515 | | | | Interval Between Onset and Death Uniter our |
| eath certificate be executed attending physician and for use as the burial-transit | edical Examilier | Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury thet initiated events resulting in deeth) Last | b. ///2 | | r as a conseque | | | | | Unknown |
| d by the deteched | | Pert II. Other elgnificant conditions o | ontributing to death t | out not res | ulting in the und | lerlying cause gi | ven in Part I. | | Anne La tinacco | stributa to the cause of death? 3 Probably 4 Unknown |
| has b | paraiding | | | | | | | perf | an eutopsy ormed? | 24b. Wara autopsy findings availabla prior to completion of cause of death? |
| Physician: The this certificate ral director, pag | נים בי | 25. Wss case refarred to medical examiner? 1 ☐ Yes 2☑ No | Hospitai: | ent 2 | ER/Outpatient | 3 DOA Oth | | eath (Check only | Yes 2⊠No one)STELLA denca 5 □Othe | 1 Yes 2 No MARIS AT MERC or (Specify) HOSPICE |
| To the Hospital or Attending Phys within 24 bours effer death. completely filled in by the funeral discompletely filled in by the funeral discompletely filled in Certification: Tre | | 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide | 28a. Date of fnju (Month, Da | iry iy Year) jury - At ho | 28b. Time of Injury | 28c. fnju Wo M 1 □ | | 28d. Describe | how injury occurre | ii (Opecity) |
| he Hospital in 24 hours he Funeral pletely filled | | 29a. Certifier 1/2 Certifying Ph (Check only one) 2 Medical Exam | yelcian: To the best niner: On the basis o and manner st | f axaminal | wledge, death o tion and/or inve | occurred at the tir stigation, in my o | me, data end piac opinion, death occ | e, and due to the curred at the time, | causa(s) and mar date end place, e | nner es stated. and due to the causa(s) |
| To the comp | - | 29b. Signeture end title of certifier | meno | | | | | | | (Month, Dey, Year) |
| 1/ | | 0. Nama and addrass of person who | | leath /Itam | 00-1 CT D | | 10 130 | | | |



State of Maryland / Department of Health and Mental Hygiene 0 7

| | | | | | | Cer | tificate of | Death | | Reg. No. |) 1 6 | . 1016 |
|----------------------------|---|----------------|--|--|------------------------------|-----------------------|---------------------------------------|---|---|--------------------------------|---|--|
| | | 91 | 1. Decedant's Nama (First, Middla, Les | st) | | | | | 2. Data of De Month | ath | Yeer | 3. Tima of Death |
| | Physic /Medi | | CLARA WE | EKS | | | | | August | - Dey | 1997 | 1105 AM |
| | Exami | | 4e. Fecility Nema (If not institution, give | a straat and number) | | | | 4b. City, Town, or | Location of Daati | | nty of Deeth | |
| 1 | | | | Spital | CENT | | | BALTIM | _ | | V/A | |
| | Funerai Director | | 407 30 3467 | ax 7. Age □M 21X1 F | (In yrs. lest bii 71 | rthday) Yrs. | Months Days | | 8. Data of Bir (Month, Da Dec • 8 | th 19, Year) 1925 | Coun | place (Steta or Foraign ntry) ntucky |
| | pus and | | Usual Rasidence of Decedant 10a. Stata 10b. County | | 10c. City, Tow | n or Loc | eation | | | | 1 | Od. Inside City Limits |
| | with the Maryland a or 28a-f show Lbe notified at | ŏ | Maryland Anne | Arundel | Gler | Bu | rnie | | | | | 1 ☐ Yas 21 No |
| | 28a notif | Director | 10e. Street end Number | | | - | 10f. Zip Coda | | | 10g. Citizen | of What Cour | ntry? |
| | E) with | | 52 Linwood Avenu | e | | | 210 | 61 | | | ·S· | |
| | deeth Cms 2 | Funeral | 11. Marital Status | 12. Was Decedant Ev | ar In U,S. | 13. W | | Hispanic Origin? (S ban, Maxican, Puart | pecify Yes or No | - 14. F | Race - Amaric | |
| 21215-0020 | 72 hours after death w naturelf, or liens 23a dical Examiner must, | by | 1 ☐ Nevar Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | Armad Forcas? 1 ☐ Yes 2 ☑ No If Yas, Give Year or Datas: | | | Yes 2 No | | o Hican, atc.) | | Bleck, White, with the second | nite |
| 5-0 | 72 bc | Completed | 15. Decedant's Ed (Specify only highast gra | ucation | 16a | . Deced | ent's Usual Occu | upation e during most of wor ed) | rkina | 16b. Kind of | f Businass/Ind | dustry |
| 121 | Man Am | nple. | Etamantery/Secondary (0-12) | College (1-4or 5+) |) | | | ed) | 9 | 0 | ** | |
| d 2 | S S S S S S S S S S S S S S S S S S S | | 8th | | | Hom | e Maker | 10 Markada Nas | - 151-4 141-44 | | Home | |
| Man | | To Be | 17. Father's Name (First, Middla, Last) | en Meadows | 5 | | | 18. Mothar's Nar | | /anhoos | | |
| Z Z | MA | 1 | 19a. Informant's Name/Ralationship (1 Howard J. Weeks | Type, Print) / Husban | | | g Addrass (Stree .nwood A | et and Number or Ru venue G | len Bur | | | |
| Baltimore | Spes 1 | | 20a. Mathod of Disposition 1 X Burial 2 ☐ Crametion 3 ☐ | | 20b. Plece o | f Dispos | sition (Nama of latory or other pi | ial Park | Data 9/2/97 | | on - City or To Burnie | own, Stata Maryland |
| Ē | artmet present | | 4 ☐ Donation 5 ☐ Other (Spacif) 21. Signature of Funeral Service Licen | | Oleii . | | Nama end Add | | | | | |
| B | Dep Imp | | Richard | E. Dar | is | | | hie Highw | Gonce I ay Balt | | | |
| | Physician | | 23a. Part1. Entar tha diseese, or comp shock, or haart failura. List only | olications that caused the cause of the cause on each line | ne death. Do | not anta | r tha moda of dy | /lng, such as cardied | or respiratory e | rrast, | | Approximata Intervel Batwean Onsat and Daath |
| ı | /Medicai | | Immedieta Ceusa (Final disaasa or condition | Pare | MONI | ^ | | | | | - 1, | 12016 |
| | Examiner | | resulting in deeth) | | ua to (or as a | | uance of): | | | | 14 | 1 DAYS |
| _ | D ≈ | ner | | | , | | , | | | | | |
| | certificate be executed office the best of the burial-transit | Examiner | Sequentially list conditions, | D | ue to (or as e | consequ | uanca of): | | | | | |
| 60, | be ex | | | | | | | | | | | |
| 68760, | phys the | edicai | that initiated avants rasulting in death) Last | Du | ua to (or as a | consaqu | ianca of): | | | | | |
| × | nding use esu | ∑ | • | d | | | | | | | | |
| Bo | atter | clar | 2.11.64 | | | | | | 1 | | | |
| 0 | the ach | Physician/ | Pert It. Other significant conditions co | | | | | | | | | the ceuse of death? |
| ٦, | es that igned b | by Pi | HyperTension, | Atherosc | leroti | <u></u> | CARDIOU | usculu D | iche" | Yes 2 SA | 6 3 Pro | bably 4 Unknown |
| Division of Vital Records, | - o D | | 2 1 2 1 | scular D | 9 | | - | | 24a Was | en eutopsy | 24b. Wa | ara autopsy findings ailable prior to |
| 000 | - D 0 | Completed | Peripheral VA. | scular c | DISEAS | SE, | Type | 2 Diasei | CS pend | ormad? | CO | mpletion of cause death? |
| Ä | 6 - 8 | E O | Hundl Nica | | | | | | 10 | Yas 2 No | 1[| Yas 2 No |
| ital | certificate rector, pag | Be C | Hypothynoi DISM 25. Was casa refarred to medical | 1 | | | | 26. Ptaca of Dea | | | | 3,40 |
| f \ | 5 00 | ToE | axaminar? 1 ☐ Yes 2 ☐ No | Hospital: | 2 ER/0 | utpetient | 3□ DOA O | ther: | loma 5 Rasi | | Othar (Specif | 'y) |
| 0 | ng Ph ter th neral | | 27. Mannar of Death 1 ☑ Naturet 5 ☐ Panding | 28a. Date of Injury (Month, Dey | 28b. | Tima of | 28c. inj | ury at ork? | 28d. Dascribe | how injury oc | curred | |
| Sio | il or Attending P sefter death. I Director: After t d in by the funera | Certification: | 2 Accidant Investigation | | | | | □Yas 2□No | | | | |
| ž | or Att efter d Direct in by | riji. | 3 ☐ Suicida 6 ☐ Could not be detarmined | 28a. Place of Injury building, atc. | y - At homa, fa (Specify) | arm, stra | at, factory, office | 9 | 28f. Location (City or To | | mber or Rura | al Routa Number, |
| | urs el | | | | | | | | | | | |
| | Hosp 24 hor Fune tely fi | edical | (Check only 2 Medical Exam | valcian: To the bast of inner: On the basis of e | xaminetion er | e, daath nd/or Inv | occurred at that astigation, in my | tima, data end place opinion, death occu | , and dua to tha rred at tha tima, | causa(s) and data and place | mennar es si ce, and due to | teted. the cause(s) |
| | To the Hospital or Attanding Ph within 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral | Mec | 29b. Signature end titla of certifier | and mannar state | d. | | 29c Licer | nse number | | 29d. Date ele | ned (Month, | Day, Year) |
| | F ₹ F 8 | | DO TO P | 4 | | 9 | | | | | | |
| | 1 | | Unito 1e | en Das | en | <u> </u> | PI | 0643 | | H4945 | 1 29 | 1997 |
| | 5 | | 30. Nama and address of person who | complated causa of daa | tn (Itam 23e) | (Type, F | rint) | 0643 THET BA | IT | . 4. | . / | |
| | Sta | te | 31. Data filed (Month, Day, Yeer) | 32 aHedistrar | s Signatura | | | ince 13/ | CIMON | L MA. | ryun | 13 |
| | Registr | | SEP 0 8 1997 | Julia Da | vidson-7 | andel | وا | | | | | |
| | | | 4 - 1001 | U | | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Dev Lugust 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Sandtown nchester Balt, more
If Under 24 Hrs. 8. Date
Hours Min. Mo Notti NA If Under 1 Year Birthplace (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthdey) Months Deys 100 M 2□ F 243-30-1554 8 Yrs. Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits → Yes 2 No attimore na 10e. Street and Number 10g. Citizen of Whet Country? ilmore 11. Meritel Stetus Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) Race - American Indien, Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married Yes 2 No Yes, Give Yeer or Detes: 1 ☐ Yes 2 No Black Specify: 3 Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry 0 Railroad Elementary/Secondery (0-12) College (1-4or 5+) boren -17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Henry Witherspoon
19e. Informent's Name/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town Stete, Zip Code) Witherspoon 20c. Location - City or Town, State - Son 6807 MD 21207 Meadow Road ehr 20b. Plece of Disposition (Name of gemetery, cremetory or other piece) Method of Disposition Dete 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service License MU 00 Intel the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiretory errest or heert feilure. List only one cause on each line. Approximete Immediate Ceuse (Finel diseese or condition resulting in deeth) RBSPIRATURY BALLUNI Due to (or es e consequença of): IMUNICOBSTRUCTION DULDUNIA Due to (or es e consequenca of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24e. Wes en eutopsy performed? 24b. Were autopsy findings aveileble prior to completion of cause of death? 1 Tes 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one) 20 No Other: A driving Home 5 Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA

Physician /Medical **Examiner**

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ate hes been signed by the a page 2 should be detached f

funeral director.

To the Hospital or Attendil within 24 hours efter death. To the Funeral Director: A

þ

Completed

Be

Certification: To

Medical

or Attending Physician: The lew requires that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

Physician

/Medical

Examiner

10a. Slete

Director

Completed by Funeral

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Funeral

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23a or 3 nust be n

filled

Pages 1 and 2 should be fill ment of Health and Mental H lant. If them 27 is marked off

ni of Health a if them 27 is or other tra

Department of Important: If any Injury or

Maryland

Baltimore,

Physician/Medicai Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lest

4 Homiclde

25. Wes case referred to medical examiner? 1 Yes

27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred

5 Pending investigation 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

29a. Certifier

the Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examinar: On the best of examinetion and/or investigation, in my opinion, death occurred et the time, dete end plece, and due to the cause(s) end menner steted. 29b. Signature end the of cartifler 29c. License number 29d. Dete signed (Month, Dey, Year)

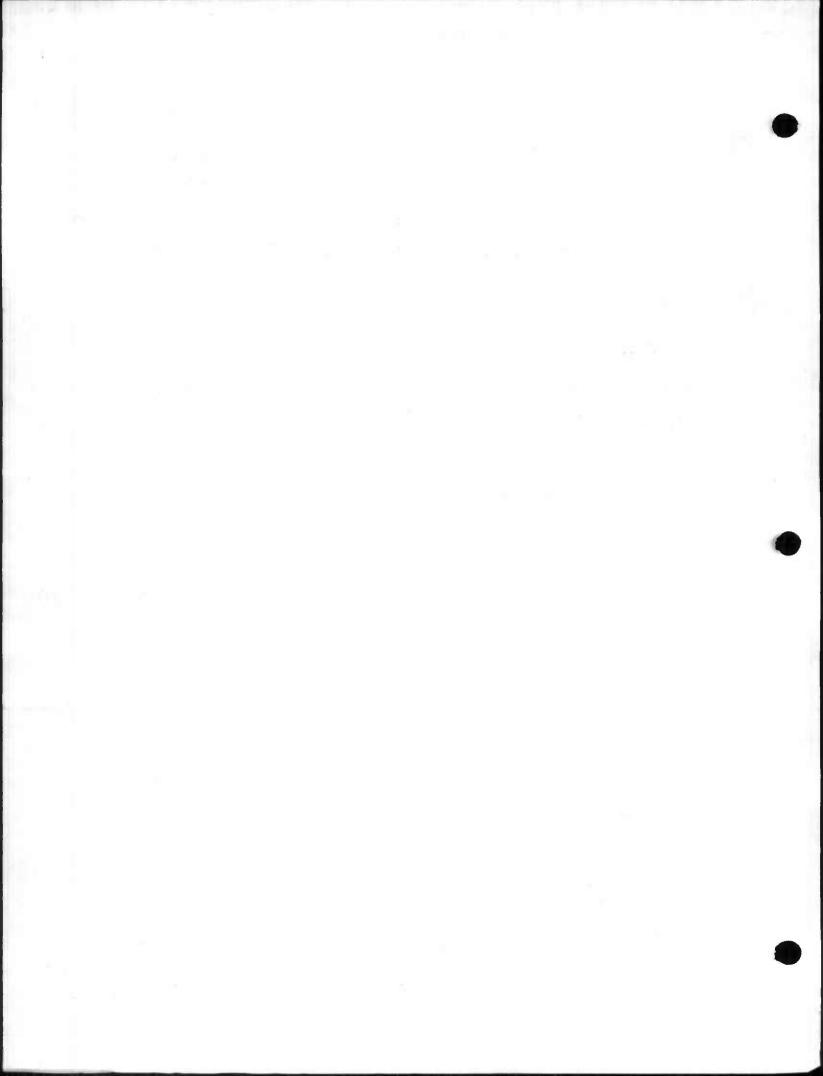
17.6) cen 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

SHAUBAS 518 CAME MIADIN 03 D. D.

State Registrar

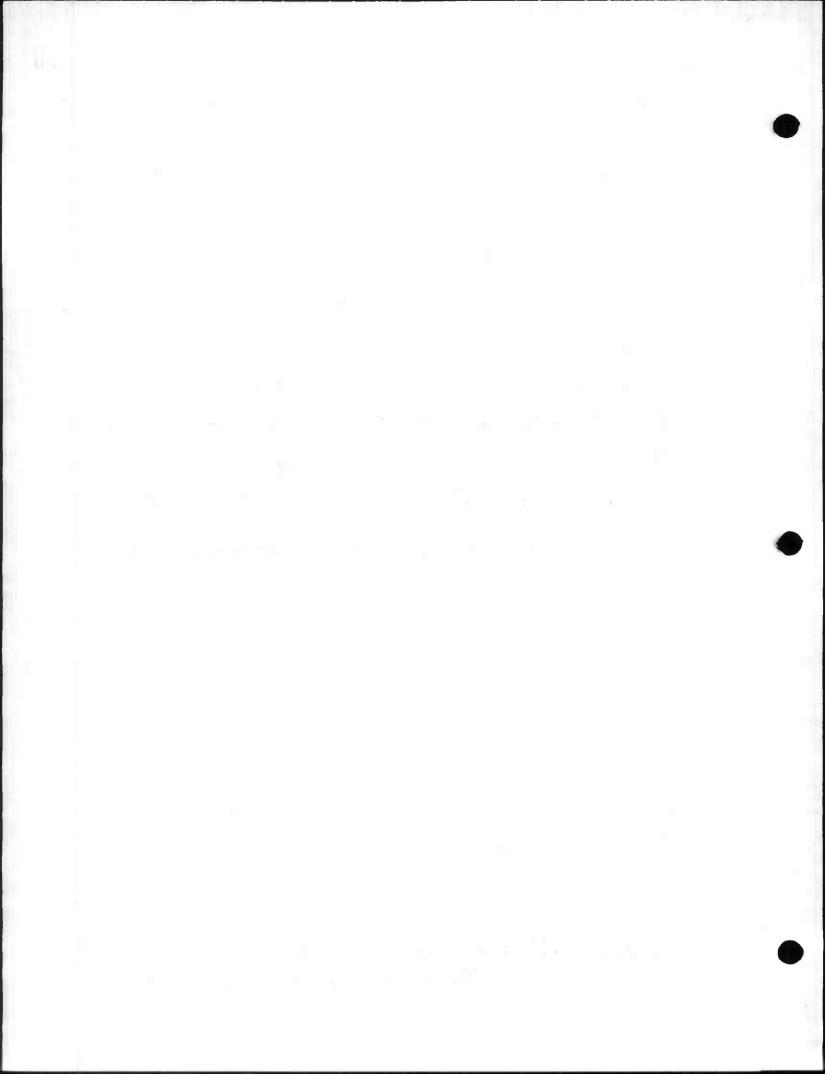
31. Dete filed (Month, Dey, Year)

32. Registrer's Signature



State of Maryland / Department of Health and Mental Hygiene 97 27018

| AMAINDA | W | Certificate of | | | | | | ath | Reg. No. | | | - 1010 | |
|---|----------------|--|--|------------------------|---------------|---|--|----------------------------|---|-------------------------------------|--------------|--|--|
| Ohusia | ion | Decedent's Name (First, Middle, Last) | | | | | | | 2. Data of Daath | | | 3. Time of Death | |
| Physici /Medi | | AMANDA | P. WATKINS | | | | | | SEPTEMBER 002 19 | | 997 | 10:25 AM | |
| Examir | | 4a. Facility Name (If not institution, give street and number) | | | | | 4b. Ci | ity, Town, or Le | cation of Death 4c. County | | of Death | | |
| | | | 1214 N.DUKELAND STREET | | | | | TIMORE | | na | | | |
| Funeral | | | Sex 7. 1 ☐ MX2X F | DAY 200 - 03 | | | | Inder 24 Hrs. ours Min. | 8. Date of Birt (Month, Da | y, Year) | 9. Birthp | Birthplace (State or Foreign Country) | |
| Director | | 220·24-3420 | - | yrs. | | | | DEC.6 | ,1903 | ,1903 DUNKIRK | | | |
| 1215 00225 inter 72 telept III South with the Manyland an "netter 10" telept 23a or 28a-t show a Medical Examine must be notified at | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City. | Town or Loc | ation | 10d. Inside City Llmits | | | | | | |
| | Director | | | | | | | X W Yes 2 | | | | X N☐ Yes 2 ☐ No | |
| | | MD na 10e. Street and Number | | BALTI 10f. Zip Code | | | RE | T. | 10g. Citizen of | What Cour | at Country? | | |
| | | 1214 N. DUKELAND STREET | | | | | 21216 | | | | | | |
| | Funeral | 11. Marital Status | 12. Was Decede | ent Ever in U.S. | 13. W | as Decedent | s Decedent of Hispanic Origin? (Spes, specify Cuban, Mexicen, Puarto | | | | | STATES can Indian. | |
| | | 1 Never Married 2 Married | | es? Tynyo | | | | | Rican, etc.) | | | White, etc. | |
| | by | XXWidowed 4 □ Divorced | XXWidowed 4 □ Divorced If Yes, Give Year or Dates: | | | Yes 2 | Xº Sp | ecify: | | Specif | y: | BLACK | |
| | Completed | 15. Decedent's to (Specify only highest g | Education rade completed) | 16a. Deced | | ent's Usual Occupetion kind of work done during most of work | | | ina | 16b. Kind of Business/Industry | | dustry | |
| | npi | Elementary/Secondery (0-12) 4 th College (1-4or 5+) DOMESTIC | | | | | etired) | y most or work | | | | | |
| A Page | Col | | | | | | 10 Mathada Nama (Films and a | | | in home | | | |
| Sill Sill Sill Sill Sill Sill Sill Sill | Be | 706777 | | | | | | | ne (First, Middle, Maiden Sumame) | | | | |
| New Marks | To | JOSEPH BOOZE PRISCILLA BOOZE | | | | | | | | | | | |
| Maryland 2 should be lise th and Mental Hy 7 is marked othy traumatic svent | | 19a. Informant's Name/Relationship EUGENE W ATK | | SON | | | reet end h TOSH | | al Route Numbe | | | | |
| - 도급하는 | | 20e. Method of Disposition | KIND - | | | tion (Name of | | COU | Date Date | T.TO ME | | | |
| Baltimore, Pener I soprature of He mportant if Hem iny Injury or other once. | | 1 vurial 2 □ Cremation 3 | | cerr | netery, creme | tory or other | place) | | Date | 20c. Location | - City or 10 | wn, State | |
| altin | | 4 Donation 5 Other (Specify) 21. Signature of Funerel Service Licensee 22. Name and Address of Facility KING MEMORIAL PARK 9-6-97 RANDALLSTOWN, MD | | | | | | | | | | | |
| Ba Depa Impo impo sny l | | | | | | | | | | | | | |
| | | Cabrelle COR MARCH FH4300 WABASH AVENUE | | | | | | | | | | | |
| SHEET, ST. | | 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypertensive Arteriosclerotic Cardiovascular Disease a. | | | | | | | | | | | |
| Physician /Medical | er | | | | | | | | | | | | |
| Examiner | | | | | | | | | | | | | |
| 100 110 | | | | Due to (or a | is a consequ | ence of): | | | | | | | |
| X 68760, certificate be executed ding physician and ise as the buriel-transit | Examiner | Securation list conditions | b | Due to (or a | e a consequi | ence of): | | | | | -+ | | |
| | | | | | | | | | | | | | |
| 68760, ifficate be exe g physician a es the buriel. | edical | | | | | | | | | | | | |
| ox 68 certifica ding ph | V/Med | resuring in dealin) Last | | | | | | | | | | | |
| 0 2 5 3 | | | l d. | | | | | | - | | - | | |
| . 0 0 0 | sici | Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? | | | | |
| P.O. the the deteched | Physician | | | | | | | | 1 Yes 2 No 3 | | | bably Winknown | |
| IS, F | by | | | | | | | | | | | | |
| Cords w requires been sign should be | Completed | | | | | | | | parto | formed? available | | ere autopsy findings aileble prior to | |
| (I) @ @ (V) | | | | | inspec | ction | completion of ceusa of death? | | | | | | |
| | | | | | | | | | 101 | es 2 No | 10 | ☐ Yes 2☐ No | |
| of Vital I | Be | 25. Wes cese referred to medicel examiner? | examiner? | | | | | | 26. Place of Deeth (Check only one) | | | | |
| | To | XXYes 2 No | | atient 2 EF | | 3□ DOA | | | ma XXResid | | | y) | |
| E g jeu | Certification: | 27. Manner of Death 1 Natural 5 Pending | | | | | Injury at Work? | | 28d. Describe how injury occurred | | | | |
| Attending r death. | cat | 2 Accident Investigation 3 Suicide 6 Could not | 30 | | | 1 Yes | | not Leasting (f | ation (Chapt and Number of Dural Bouts Number | | | | |
| Division or Attending effer death. Director: After | artif | 4 ☐ Homicide determine | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| Division To the Hospital or Attendit within 24 hours efter death. To the Funeral Director: A completely filled in by the fi | | 29a. Certifier 1□ Certifying P | Cartifular Dhusialan: To the heat of my keeping and a section of the section of t | | | | | | and due to the | | ALLES AND | | |
| 24 hd 24 hd Fun etely | edical | | (Check only 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the ceuse(s) | | | | | | | | | | |
| o the o the ompl | Med | and marrier stated. | | | | | cense number | | | 29d. Date signed (Month, Dey, Year) | | | |
| F # F 8 | | 111 | 1111111 | | | | | F | | | | | |
| | | 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) | | | | | | | | SEPTEMBER 02,1997 | | | |
| | | Theodore King M | | _ | | | Balt | imore. | Marylar | nd 2120 | 1 | | |
| Sta | te | | | strar's Signatur | | | | | | | | | |
| Registr | | SEP 0 8 1997 | gruna Days | loon-Hand | lee | | | | | | | | |



| | | | State of | Maryla | | artmen rtificate | | | d Mental Hy | giene g Reg. No. | 7 | 270 |)19 |
|--|-----|--|---|-----------------------------------|----------------------------------|------------------------------|-------------------------|-------------------------------------|---|----------------------------------|-------------------------|----------------------------|-------------------------------|
| | ľ | . Decedent's Neme (First, Middle, La | ist) | | | | | | 2. Dete of De | | Vee | 3. Tin | ne of Deeth |
| Physician /Medical Examiner | | Maxine Johnson e. Fecility Neme (If not institution, given | | White | | | | 4b. City, Town, | Month Sept. (| Dey 03, 199 h 4c. Coun | Yeer 7 tv of Deatl | | 15 AM |
| LAdminer | ı | 33 East Seminary | Διποημο | | | | | Luther | ri 110 | Da1 | timor | · Co | |
| Funeral | | . Sociel Security Number 6. 5 | Sex | 7. Age (In yrs | s. last birthdey, | | 1 Yeer | If Under 24 | Hrs. 8. Dete of Bir | rth | | | ete or Foreign |
| rector | | 220-48-6490 Usuel Residence of Decedent | 1□M 2ਊF | 76 | Yrs. | Months | Deys | Hours N | Min. (Month, De Oct. 23 | | De. | intry) Lawar | е |
| ž u | 1 | 0a. Stete 10b. County | | 10c. C | City, Town or L | ocation | | | | | | 10d. Insid | le City Limits |
| tor feet | 1 | Maryland Baltimo | re Co. | L | utherv: | ille | | | | | | 1 🗆 | Yes 2 No |
| be notified Director | 1 | 0e. Street and Number | | 1 | | 10f. Zip | Code | | | 10g. Citizen o | f Whet Co | untry? | |
| | | 33 East Seminary | Avenue | | | 210 | 193 | | | U.S | .A. | | |
| Funeral | 1 | 1. Meritel Status | 12. Wes Dece | dent Ever in | U,S. 13. | | | Ilspenic Origin | (Specify Yes or No uerto Rican, etc.) |)- 14. R | ce - Amer | | n, |
| | | 1 Never Married 2 ☐ Married | 1 Yes If Yes, Give | 2X No | | 1 ☐ Yes 2 | | | derito micari, etc.) | | eck, White | | |
| d by | | 3 Widowed 4 Divorced | Yeer or De | tes: | | | | -py- | | Орос | ity: Wh | ite | |
| Completed | | 15. Decedent's E (Specify only highest gr | ducation ede completed) | | 16e. Dece (Give | dent's Usue kind of wor | l Occup | petion during most of d) | working | 16b. Kind of | Business/I | ndustry | |
| dwo | | Elementery/Secondery (0-12) | College (1- | | | | e retire | d) | | T-3 | | | |
| ပိ | 1 | 12 yrs. 7. Fether's Neme (First, Middle, Last | 4 yr | s. | Teac | ner | - | 19 Mother's | Neme (First, Middle | | ation | (1 | |
| To Be | | | | | | | | | | | ille) | | |
| 10 | | H. Clayton 19e. Informent's Neme/Relationship | John | ison | 10h Maili | na Addross | (Ctroot | Mari | on Re | ynolds | - Cloto 7 | in Code l | |
| | | Charles W. White | | 1 | | | | rv Ave. | | | | | 1093 |
| | 2 | Oe. Method of Disposition | / IIusbanc | | Place of Disp | nsition (Nem | ne of | | Dete | 20c. Location | | | |
| | | 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ | | | cemetery, cre | | | | 10,572 | | | | |
| suce. | - | 4 ☐ Donetion 5 ☐ Other (Special Signature of Funeral Service Lice) | | To | ownsend | | | | /6/97 | Townse | _ | | |
| SUC | - | 100 | ances | | | z. Name en | u Addre | as or recitity | Ruck Tows 1050 York | | | | |
| cian lical | | 23a. Pert1. Enter the disease, or com shock, or heart failure. List only | plicetions hat ca one cause on ee | used the dee | eth. Do not en | ter the mode | e of dyli | ng, such es car | dlac or respiretory e | orrest, | | Approx Interve Onset | Imete Between and Deeth |
| ner | 1 | mmediete Ceuse (Finel diseese or condition esulting in deeth) | e. CVA, I | | ent,Thi | | is | Cereber | al | | 1 | Immed | diate |
| iel-transit Examiner | | | ASCVD | | | | | | | | | 10 Ye | ears |
| the buriel-transit dical Examir | 1 5 | Sequentially list conditions, | 0. | Due to | (or es e conse | quence of): | | | | | 1 | | |
| E E | 100 | Sequentially list conditions, freny, leeding to immediate seuse. Enter Underlying Cause (Disease or Injury | C | | | | | | | | 1 | | |
| | 1 0 | het initieted events esulting In death) Lest | | Due to (| or es e consec | quence of): | | | | | 1 | | |
| Me | | L | d | | | | | | | | į | | |
| i m | L | | | | | | | | | | | | |
| ysic | P | ert II. Other eignificant conditions of | ontributing to dea | ath but not re | sulting In the u | inderlying ce | euse giv | ven in Pert I. | 23b. Dld | tobacco use o | ontribute | to the car | se of death? |
| be deteched for use as by Physician/Me | 1 | Partial Lobectomy | 2 to 0 | ld Gra | nulomat | ous D | ise | ase, | 1 🗆 | Yes 2 No | 3□Pr | obably | 4 Unknown |
| | | | | | | | | | 240 Was | en eutopsy | 24b V | Vere euto | osy findings |
| page 2 should | 1 | Pulmonary. | | | | | | | | omed? | 8 | veilable p completion | rior to |
| U D | | | | | | | | | | | | deeth? | |
| S | | | | | | | | | 1 🗆 | Yes 2 No | 1 | Yes | 20 No |
| Be Be | 2 | 5. Wes case referred to medical exeminer? | Hospitel: | | | | Ott | nor: | Deeth (Check only | | | | |
| . To | 2 | 1 ☐ Yes 2X No 7. Menner of Deeth | 1 U In | | 28b. Time o | | A | 4 LI NUISIN | g Home 520 Resi | | | cify) | |
| In by the funer ertification | | 1 X Neturel 5 ☐ Pending investigation | | , Dey Year) | Injury | M | Bc. Injui Woi 1 □ | rk? Yes 2 □ No | 200. Describe | now injury occ | umeu | | |
| completely filled in by the funeral director, page Medical Certification: To Be Com | | 3 ☐ Suicide 6 ☐ Could not be determined | 289. Piece | of Injury - At I g, etc. (Spec | home, farm, st ify) | reet, fectory, | , office | | | Street end Nun wn, Stete) | n <i>ber or R</i> u | rei Route | Number, |
| edicai | 2 | 9a. Certifier (Check only one) Check only 2 Medical Example 1 | yelclan: To the baselinar: On the baselinar | sis of exemin | owledge, deet etion end/or In | n occurred e vestigation, | t the tir | me, dete end pl ppinion, deeth o | ece, and due to the ccurred et the time, | ceuse(s) and r date end plece | nenner es e, end due | steted. to the cau | se(s) |
| ¥ e | 2 | 9b. Signeture end title o certifier | al | | _ | 29c. | Licens | se number | | 29d. Dete sign | ed (Month | , Dey, Ye | ar) |
| | | 1 free | Jus | m 5 | 5 | D0 | 178 | 2 | | Sept. | | | |
| | 3 | 0. Neme end endress of person who | | | | | | | | | | | |
| |] | Lee E. Gresser,M. | D. 390 |)1 Gre | enspri | ng Ave | . B | altimor | e, Md. 21 | 211 | | | |
| State | 3 | 1. Dete filed (Month, Day, Year) | 32/ Re | and the section | et Mandes | 2 | | | | | | | |

DHMH 16 Rav 6/95

A STATE OF STREET

Edward W. Ditto, III,
31. DATE FILED (Month, Day, Your)
AUG 2 8 1997

M.D.

| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician. | , certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should | = | ed, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|---|---|---|---|
| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the dear | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the att | be filed within 72 hours after death with the State Dept. of Health and Menta | IMPORTANT: if item 28 is marked, or item 23 shows any injury, |

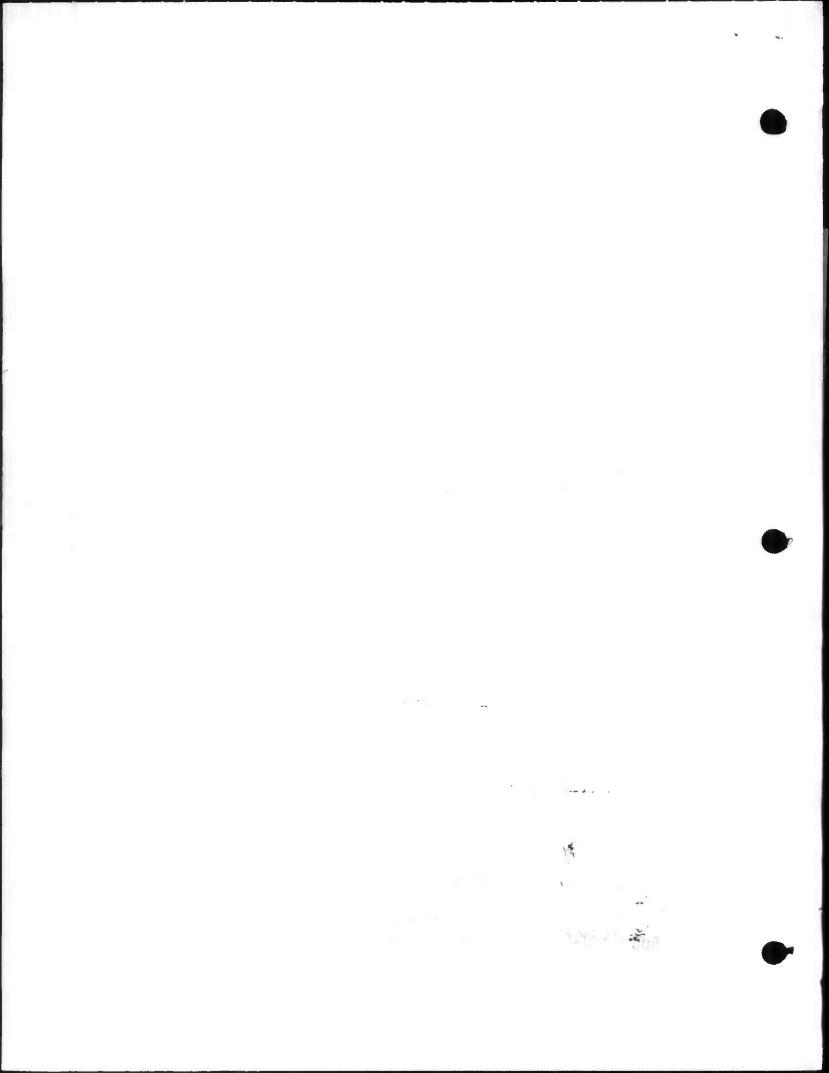
| | | | | | | | | | | | 97 | 27020 |
|-----------------------------------|---|--|--|--|---|--|------------------|--|---|--|--|--|
| | 1 - STATE REGISTRAR | STATE OF N | MARYLAND / | | TMENT OF | | | MENTA | L HYGIENI | E | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | - 01 | | TOATE OF | DEA | 1 | 2 DATE | OF DEATH | | 1. | . TIME OF DEATN |
| | | CHER | ASHLEY | 7 | | | | MONT | TH DA | | YEAR | |
|] 1 | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. les | | IF UNDER 1 YEAR | IF UNDER | 94 1000 | | ust 25 | | | 8:28 P M ACE (State or Foreign |
| | | 1 💢 M 2 🗌 F | | YRS. | MONTHS DAYS | HOURS | MIN. | (Mont | th, Day, Year) | | Country) | ATTITUTE OF THE PARTY OF THE PA |
| | 227-09-9655 9a. FACILITY NAME (If not institution, give s | | 89 | | 9b. CITY, TOWN | | | | 1 16,1 | | NEW TY OF DEAT | York |
| œ | | | -1 | | | | | ATH | | | | |
| 5 | Washington Count | y nospiia | a I | | па | gerst | OWII | | | AA | asiiii | ngton |
| DIRECTOR | 10a. STATE 10b. COUNTY | 1 | | 10c. CIT | Y, TOWN OR LOC | ATION | | _ | | | 10 | od. INSIDE CITY |
| a | Maryland Was | hington | | | Wil | liams | port | | | | - 1 | LIMITS? |
| | 10e. STREET AND NUMBER | | | | 1 | of. ZIP COD | E | | | 10g. CITIZ | EN OF WHA | AT COUNTRY? |
| FUNERAL | Milestone Garden | Apts. Ap | t. 12C | | | 2179 | 5 | | | | US | SA |
| 3 | 11. MARITAL STATUS | 12. WAS DECEDEN | T EVER IN U.S. AR | MED | | | | | N? (Specify Yes | or No- | I4. RACE - | - American Indian, White, etc. |
| | 1 Never Married 2 Married | IF YES, GIVE V | YES 2 1 | NO | | pecify Cuba S 2 X NO | | | Rican, etc.) | | Specify: | White, etc. |
| ВУ | 3 💢 Widowed 4 🗌 Divorced | | WWI | | | | | | | | Whi | ite |
| | 15. DECEDENT'S EDUC (Specify only highest grade | CATION completed) | (G | ive kind of | USUAL OCCUPAT | | na | 181 | b. KIND OF BUS | INESS/INDU | STRY | |
| | Elementary/Secondary (0-12) | College (1-4 or 5 | - Ma | . Do NOT u | se retired.) | | | | | | | |
| COMPLETED | 12 | 1 | | Ma | nager | | | | | extil | е | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | | - | | | Middle, Maiden | , | | |
| BE | <u>Calvin Lewis As</u> | <u>hley, Sr</u> | | | | | <u>Minn</u> | | | House | | |
| 0 | 19a, INFORMANT'S NAME (Type/Print) | | | | ADDRESS (Street | | | | | | | |
| | Bill Ashley | | | | Sand Ro | | ne C | 7 - | | | | |
| | 20q, METNOD OF DISPOSITION 1 ABurial 2 Cremation 3 Rem | ovel from State | cemetery cos | metory or r | OF DISPOSITION (I | | | 1 | | CATION — C | | |
| | 4 Donation 5 Dother (Specify) | ensuel 1 | Green | lawn | Memori | AND ADDRE | | | -9/ W | IIIIa | mspor | -+, MD |
| | 1115 1111 | 71/ 1 | | | Osbo | rne F | uner | al H | lome 42 | 5 S. | Conoc | cocheague S |
| | 1///1920001 | LYZIVI | 740 | | | | | | | | | |
| | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | (V-, | _ | - | | | | | Wi | lliam | | H, MD 21795 |
| | 23. PART I. Enter the disesses, or o | complications tha | t caused the de | ath. Do | | | | | | | sport | Approximate |
| | 23. PART I. Enter he disesses, or o shock, or heart fallure. IMMEDIATE CAUSE (Final | complications tha List only one cau | t caused the de ise on each line | eath. Do | | | | | | | sport | |
| | immediate Cause (Final disease or condition | List only one cau | ise on each lina | i. | not anter the m | | | | | | sport | Approximate Interval Between |
| | immediate cause (Final | a. Cardio | ise on each lina | ary | not anter the m | | | | | | sport | Approximate Interval Between Onaat and Death |
| N | IMMEDIATE CAUSE (Final disease or condition resulting in desth) | a. Cardic DUE TO Seven | Pulmon (OR AS A CONSECTE Lung | ary OUENCE C | Failure | | | | | | sport | Approximate Interval Between Onaat and Death |
| TION | IMMEDIATE CAUSE (Final disease or condition resulting in desth) Sequentially list conditions, if any, leading to immediate | a. Cardic DUE TO Seven | Pulmon (or as a consected Lung (or as a consected Lung | ary OUENCE C | Failure Figure usion | ode of dy | | | | | sport | Approximate Interval Between Onast and Death hours 38 days |
| ICATION | Sequentially list conditions, if amy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or linjury | a. Cardic DUE TO Seven DUE TO and N | Pulmon (OR AS A CONSECUTE LUNG (OR AS A CONSECUTE LUNG (OR AS A CONSECUTE LUNG) | ary ouence o Cont ouence o Rib | Failure Failure Fination Fractu | ode of dy | | | | | sport | Approximate Interval Between Onast and Death hours |
| TIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | a. Cardic DUE TO Seven DUE TO and N | Pulmon (or as a consected Lung (or as a consected Lung | ary ouence o Cont ouence o Rib | Failure Failure Fination Fractu | ode of dy | | | | | sport | Approximate Interval Between Onast and Death hours 38 days |
| CERTIFICATION | IMMEDIATE CAUSE (Final disease or condition resulting in desth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in daath) LAST | a. Cardic DUE TO Seven DUE TO and N | Pulmon (OR AS A CONSECUTE LUNG (OR AS A CONSECUTE LUNG (OR AS A CONSECUTE LUNG) | ary ouence o Cont ouence o Rib | Failure Failure Fination Fractu | ode of dy | | | | | sport | Approximate Interval Between Onast and Death hours 38 days |
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217 W. Washington St.

32 MEDISTRAN'S SIGNATURE
Fuha Davidson-Randall

21740

Hagerstown, MD



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** Jackson HAROLD BRANTLEY 22,1997 820AM /Medical 4b. City, Town, or Location of Death 4e. Fecllity Name (If not institution, give street and number) 4c. County of Deeth Examiner SALISBURY CENTER, GENESIS ELDERCARE SALISBURY, MD. WICOMICO 5. Sociel Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 08 10 19 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** I∏M 2□F Months Days Hours 405-01-9079 Yrs 78 Kentucky Director Usual Residence of Decedent with the Meryland 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits "natural", or frame 23a or 28a-f show Yes 2□No Director Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 901 West Schumaker Manor Drive Funeral 21804 U.S.A. 12. Was Decadent Ever In U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuben, Mexican, Puerto Rican, etc.) filed within 72 hours efter 15 Yes 2 No Army If Yes, Give Year or Dates: Alr Force 1 Never Merried 3 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: White by 3 ☐ Widowed 4 ☐ Divorcad Completed traumatic event, the Medical 16a. Decadent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mentel Hygiene. ant: If item 27 is marked other then 'ury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Postal Worker U.S. Postal Service 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be 20 Brantley Walter Lula Perkins 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 901 West Schumaker Manor Drive, Salisbury, MD 2'804 Mary D. Brantley-Wife 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burlal 2 ☐ Cremetion 3 ☐ Removal from State permit. Page Depertment of Important: If any injury or 4 ☐ Donetion 5 ☐ Other (Specify) 8/23/97 Salisbury, Maryland Salisbury Crematory 21. Signature of Funeral Service Liberases 22. Name end Address of Facility Holloway Funeral Home, P.A. CFSP 50! Snow HIll Road, Salisbury, MD 23a. Pert1. Enter the disease, or complications to the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on profile. Approximate Interval Between Onset and Death **Physician** /Medicai Immediate Cause (Finel accedars disease or condition resulting in death) Examiner Due to (or es e consequence of) Examiner The law requires that the death certificate be executed physician and s the buriel-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. ofel es Physician/Medical Due to (or as a consequenca of): use signed by the e P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Natural efter death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homleide 24 hours e Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date and plece, end due to the cause(s) end menner as steted.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end pleca, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho To the Func (Check only one) 29b. Signature and title of cartifier 29d, Date signed (Month, Day, Year) 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 1104 HEALTHWAY DR., SALISBURY, MD. 21804 32. Registrat's Signature 31. Dete filed (Month, Day, Year) State AUG 26 1997 Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 97

ne 97 27022

| | | | | | | Cer | tificate | of | Death | | | Reg. No. | 131 | Som I G | las has |
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| | Physic /Medi | | CHESTER | W. | | BUN | TING | | | | Month 8 | Dey 2/ | 97 | 08 | 45 fm |
| 7 | Exami | | 4a. Fecility Nama (If not institution | on, give street and number, | | | | | 4b. City, To | wn, or Lo | ocation of Deat | . 1 | nty of Deeth | | |
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| | death with the Maryland rm 23e or 28e-f show | Directo | 10e. Street and Number | | | | 10f. Zip C | | | | | 10g. Citizen | | ntry? | |
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| | er da | Funeral | 11. Marital Stetus | 12. Wes Decedant Amed Forces? | | 13. V | Wes Deceder f Yes, specify | of F Cub | fispanic Ori an, Maxican | gin? (Sp i, Puarto | ecify Yes or No Rican, etc.) | ⊢ 14. F | Race - Amari Black, White | | |
| 20 | be filed within 72 hours after death with the Maryla vial Hygiene. "natural", or Nema 23a or 28a-f ahov d'other than "natural", or Nema 23a or 28a-f ahov event, the Modical Examiner must be nout ad at | by F | 1 Nevar Married 2 Mei | M Man Chin | No 1942–45 | 1 | I□Yes 2 | No | Specify: | | | Spe | city: WH | ITE | |
| 8 | hour ural | P | 3 ☐ Widowed 4 ☐ Divorce | | | | | | | | | | | | |
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| | Hygid The T | | 17. Fether's Neme (First, Middle | . Last) | | roc | נאון על | LEC | | r's Nem | e (First, Middle | | | RIOUI | TORE |
| Maryland | build be filled with Mental Hygiene arked other than | o Be | JACOB BUNT | TNG | | | | | ETH | | LEWIS | | , | | |
| 2 | 2 should and Men Is marke | 2 | 19e. Informent's Neme/Relation | | 19h | Meiiin | n Address (| Street | | | al Route Numb | | wn State 7 | n Code) | |
| S | | | RUBY M. BUNTIN | | | | - | | | | WHALEY | | | | 1872 |
| 6 | Haalth Haalth Jem 27 I | | 20e. Method of Disposition | G/WIFE | 20b. Plece of | Dispo | sition (Name | of | | 110, | Dete | 20c. Locatio | | | |
| Baltimore, | ages intof | | 1 X Burial 2 ☐ Cremetion | | | | natory or oth | | | | 122/07 | | | | |
| = | ortan | | 4 Donetion 5 Other (S | | RISHOI | | LE CE | | | | 3/23/97 | BISHOI | VILLE | , MAI | CYLAND |
| Ba | permit. Pages 1 and 2 Department of Health a Important: If Item 27 It any Injury or other tra once. | | 77/10 | 17/2/ | | 1 | | | | • | | | | | |
| _ | | | - Charles | W Hast | 0 | | | | | | ME, SEL | | E, DE. | LAWAR | E 1997 |
| | | | 23a. Pert1. Enter tha diseese, o shock, or heert feilure. Lis | ir complications thet cause it only one cause on each i | the daath. Do i | not ente | er the mode (| of dyli | ng, such es | cardiac | or raspiratory a | rrest, | t I | Approxim | Between |
| | Physician /Medical | | Immediate Cause (Finel | | , , | | | | | | | | i i | Oriset a | nd Deeth |
| | Examiner | | disease or condition resulting in deeth) | a. pr | 05/27 | 9 | Ci | 20 | ur | | | | | 50 | yeors |
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| | pe inst | Examiner | | b | | | 27 | | | | | | | | |
| _6 | and and | Xar | Sequentially list conditions, if eny, leading to immediate | | Due to (or es a | conseq | uence of): | | | | | | į | | |
| 68760, | requires that the death certificate be executed seen signed by the attending physician and hould be datached for use as the bunisi-transit | | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events | с | | | -11112-01-01 | | | | | | | | |
| 89 | ficate phy is the | Medical | resulting in deeth) Lest | | Due to (or as a | consequ | uence of): | | | | | | 1 | | |
| × | certi | M | | d | | | | | | | | | | | |
| Bo | hat the death cert ed by the attendin datached for use | Physician/ | Date of Other death | | | | | | | | | | | | |
| P.O. | t the d | 1ys | Pert II. Other significant conditi | ons contributing to death b | ut not resulting li | n tha ur | ndariying cau | se gr | en in Pert I | | | tobacco use | / | | |
| | es that igned b | | purumo | عزدم | | | | | | | 10 | Yes 2 TN | 0 3∐PM | obably 4 | Unknown |
| Records, | uires Per la bien | d by | <i>'</i> | | | | | | | | 24a. Was | an autopsy | 24b. W | /ere autop | sy findings |
| 00 | 773 00 | ete | | | | | | | | | | ormed? | O. | vailable pri ompletion | or to |
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| <u>a</u> | defant. The Lector, page | | | | | | | | | | 1 🗆 | Yes 2 No | 1 | ☐ Yes 2 | !□ No |
| Vital | | Be | 25. Wes case referred to medical examiner? | Managhali (| | | | Oth | or | | h (Check only | | | | |
| of | Phys rai di | - To | 1 Yes 2 No 27. Mennes of Deeth | 1 🗆 Inpate | | tpatien | | | 4 LI NU | 1 | me 5 Resi | | | fy) | |
| - Lo | Aftar fune | Certification: | 1 ☐Neturel 5 ☐ Pendi | ng 28a. Dete of Inju (Month, De Igetion | y Year) | njury | M 200 | . Injur | rk? Yes 2 🔲 I | | 200. Describe | now injury oc | curred | | |
| Si | death death rtor: | Ica | 3 Sulcida 6 Could | not be | une At home fo | | | | 163 2 | | 28f. Location (| Street and Mi | mhor or Du | ral Davida A | himbor |
| Division | or A Bittar Direction by | in in | 4 ☐ Homicide determ | building, et | ury - At home, fe c. (Specify) | um, stre | et, rectory, t | mice | | | City or To | wn, State) | inber or nur | El Houle IV | umber, |
| _ | pital Surs Peral filled | | 29e. Certifier 1 Certifyin | ng Physician. To the boot | of muclimous do do o | do oth | | 4h - 4!- | | 1 -1 | | | | -1-1-1 | |
| | Hos 24 h Fun stely | edicai | | ng Physician: To the best i Examiner: On the basis o | f examinetion en | d/or inv | restigetion, in | my o | pinlon, dee | th occurr | and due to the red et the time, | date and place | manner as ca, and due | stated. to the caus | e(s) |
| | To the Hospital or Attending Phyinh 24 hours after death. To the Funeral Director: After the completely filled in by the funeral | Me | 29b. Signature and title of certific | end manner st | | | 29c. l | icans | e number | | | 29d. Data sig | ned (Month | Day Yes | r) |
| | F 3 F 8 | | · Mr | | | | | | 128 | 3 | | 0/0/ | 27 | ,, | |
| | | | Phy. | 11615 - | | | | / 1 | (40) | | | 8/2/ | 7 7 | | |
| | 8+1VA | | 30. Name and address of person | DUSILIO | leath (Item 23a) | Type, I | | , | | | 2.0 | i I | | | |
| | | | 97-33 # (31. Dete filed (Month, Dey, Year, | 2 / The Car | DVI-P | | Ber | 110 | -, on | J | 9181 | (| | | |
| | Sta Registr | 100 | AUG 2 2 199 | 1 | ar's Signature | Ц | | | | | | | | | |
| | 3 | | MUUAAIJ | | | | | | | | | | | | |

55 # 220-25-428 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiane. glovic Braughler SS Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97

27023

| | | | | | | | Cer | titicat | e or l | Jeath | | | Reg. No |). | | | |
|---|----------------|---|-------------------|-------------------------|--|--------------|-------------------|-------------|--------------------|---------------------|------------|--------------------------------|----------------------------|----------------|---------------------|------------|---------------------------------------|
| Physici | ian | Decedent's Neme (First, Michael Control of the | ddie, Last |) | | | | | | | | 2. Dete of D | eeth De | v | Year | 3. Tim | e of Deeth |
| /Medi | | GLORIA | | MAE | | BRA | UGH1 | LER | | | | Augu | | 0,1 | | 23 | 52 |
| Examir | ner | 4a. Facility Neme (If not institu | tion, give | street end nu | imber) | | | | 4 | b. City, To | wn, or Lo | cation of Dea | th 4c | . County | of Death | | |
| | Ш, | PENINSULA REGI | - | | | | | W11 1 | | | ISBU | | | | COMIC | | |
| Funerai | | 5. Social Security Number | 6. Se | x]M 2 ™ F | 7. Age (In | | thday) Yrs. | Months | 1 Year Days | If Under Hours | Min. | 8. Date of Bi (Month, D | irth le <i>y, Year)</i> | | 9. Birthpl Count | ace (Ste | te or Foreign |
| Director | | 220-28-4299 Usual Residence of Decedent | | | 64 | | 115. | | | | | May 21, | 1933 | | Maryla | and | |
| pue * | | 10a. State 10b. Cour | nty | | 10c | . City, Tow | n or Loc | cation | | | | | | | 10 | d. Insid | e City Limits |
| Mary | ō | Maryland W | icom | ico | | н | ebro | າກ | | | | | | | | | es 2K No |
| with the Marylend a or 28a-f show be notified at | Director | 10e. Street and Number | | | | | CDIC | 10f. Zic | Code | | | | 10a Cit | izen of V | Vhat Count | n/? | |
| With Sa or | | 330 Lillia | n St | root | | | | | - | 11000 | | | | | | ., | |
| death with the Marylend ms 23a or 28a-f show r mast be notified at | Funeral | 11. Maritel Status | 11 31 | 12. Was Dec | | in U,S. | 13. W | Vas Dece | | 1830 ispanic On | igin? (Spe | ecify Yes or N Rican, etc.) | 0- | USA 14. Rac | e - America | an Indian | 1, |
| or he | | 1 Never Married 2 M | erried | Armed F | 2 X No | | | _ | | | | Rican, etc.) | | Blac | k, White, e | itc. | |
| ours : | by | 3 Widowed 4 □ Divorc | ed | If Yes, Gi Year or D | ive Dates: | | 1 | ☐ Yes | 2 No | Specify: | | | | Specify | : Wh | ite | |
| be filed within 72 hours tal Hygiane. d other than "naturel", event, on Medical Exp | Completed | 15. Deced (Specify only high | ent's Edu | cation e completed) | | 16a. | Deced | ent's Usu | al Occupi | ation duning mos | t of work | ina | 16b. K | Ind of Bu | usiness/ind | ustry | |
| within ane. than | John | Elementary/Secondary (0-12 | | | 1-4or 5+) | | life. D | O NOT u | se retired |) | | | | | | | |
| hed with | | 12 | | _ | | | Sec | creta | ry | | | | | | of Ma | ryla | nd |
| | Be | 17. Father's Name (First, Middle Thomas Sta | | | | | | | | Els: | | First, Middle | | Sumern | 10) | | |
| 2 should be filed with and Mental Hygiane. Is marked other than reumatic event, the | 70 | | | | | | | | | | | Porte | | | | | |
| d 2 should th and Men 7 Is marke treumatic | | 19a. informant's Name/Relation | | | | | | _ | | | | al Route Numi | | | | Code) | |
| 1 and Health em 27 ther tr | | Debbie Shock 20a. Method of Disposition | rey/ | Daugnt | | b. Plece of | | | | Ct. | , Sa. | lisbury Date | 7 | | City or Tov | un State | |
| Pages nent of nrt: If Ne iry or o | | 1 ☑ Burlal 2 ☐ Crematio | | | State | cemete | ry, crem | etory or o | ther plec | | 1 | 8/23/97 | | | | wii, Otati | |
| artme srtani srtani | | 4 ☐ Donation 5 ☐ Other 21. Signeture of Funeral Service | | | S | pringh | | | | dens | | 0/23/9/ | нер | ron | MD | | |
| permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is eny Injury or other tre once. | | 1101 | 100 | | | | ٤٤. | Ho11 | oway | Fune | eral | Home | | | | | |
| | | 22a Part 1 Enter the disease | ell | long | <u></u> | leath De | | 501 | Snow | Hil: | L Rd | ., Sali | sbur | y, 1 | 1D 21 | | |
| Discolates | | 23a. Part1. Enter the disease, shock, or heert fallure. L | ist only or | ne cause on | each line. | Betti. Doi | TOL BITTE | I the mod | ie or dyin | g, such es | cardiac | or respiratory i | arrest, | | | | Between nd Deeth |
| Physician /Medical | | Immediate Cause (Final | | | | . / | | 1. | | ٧, | 1. 4 | _ | | | | | |
| Examiner | | disease or condition resulting in deeth) | 4 | 9 | | e brow | | | - 6 | hom | rent | | | | | 20 | ays |
| | ē | | | | 1 11 | o (or as a | 1 | 1 | - | 9 | 1 1 | | | | į | | |
| icate be axecuted physician and s the burial-transit | Examiner | Sequentially list conditions | | 0. ——— | le ++ | o (or es a | - | ru (ov | | NOW | 941 | | | | | | |
| be axacuted ician and burial-transi | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events | | | | 0,000 | 301100 q 0 | 301100 01). | | | | | | | | | |
| ite be nysici | n/Medical | Ceuse (Disease or Injury thet initiated events resulting in death) Last | 5 |) | Due t | o (or as a c | onsequ | ience of): | | | | | | | | | |
| E 016 | Ved | resulting in Obatti) Last | | | | | | | | | | | | | i | | |
| | | | | 1 | | | | | | | | | | | - | | |
| a dag | Physicia | Part II. Other significant condi | tions cor | ntributing to d | leath but not | resulting in | the un | derlying | ause give | en in Part | l. | 23b. Did | tobacco | use col | ntribute to | the cau | se of death? |
| requires that tha death ween signed by the ette hould be detached for | | dialites | | Lic | | | | | | | | 1/2 | 108 2 | □ No | 3 Prob | abiy 4 | Unknown |
| res the signed to be of | by | 0 - 0 - 0 - 0 - 0 - 0 - 0 - 0 - 0 - 0 - | MIE II | 11.17 | | | | | | | | | | | | | |
| v require been si should I | etec | | | | | | | | | | | 24a. Wa: perf | s an auto omed? | psy | ava | llable pr | sy findings for to of ceuse |
| 2 6 6 | Completed | | | | | | | | | | | | | _ | | leath? | 01 00030 |
| : The cate h | | | | | | | | | | | | 10 | Yes 2 | No | 1□ | Yes | 2□ No |
| Physician: The this certificate ral director, pag | Be | 25. Was case referred to medi- examiner? | | fospital: | | | | | 011 | | of Deatl | h (Check only | one) | | | | |
| this aldi | . To | 1 Yes 22 No 27. Menner of Death | | 2 | | 2 ER/Ou | - | | | 4 L N | | me 5 Res | | | |) | |
| After After fune | F | 1 Neturel 5 ☐ Pen | ding stigation | 28a. Date (Mon | th, Dey Yea | | Time of njury | м | 28c. Injun Work | rat ⟨? Yes 2□ | | 28d. Describe | now inju | ry occuri | 90 | | |
| deet ctor: y the | fica | 3 ☐ Suicide 6 ☐ Coul | d not be | 28e. Place | e of Injury - A | At home fa | rm stre | | | 103 2 | | 28f. Location | (Street at | nd Numb | er or Rural | Route I | Jumber |
| aftar Dire d in b | Certification: | 4 ☐ Homicide dete | mined | | ing, etc. (Sp | | iii, 5110 | ot, laotor | y, 011100 | | | City or To | | | 0, 0, 110, 0, | 1100101 | , , , , , , , , , , , , , , , , , , , |
| To the Hospital or Attending Physician: within 24 hours after deeth. To the Funeral Director: After this certific completely filled in by the funeral director. | | 29a. Certifier Certify | ing Phys | sician: To the | best of my | knowledge | , death | occurred | et the tim | e, date an | d place, | and due to the | ceuse(s |) end ma | nner as ste | eted. | |
| Me Fu | edicai | (Check only 2 Medic | ai Examir | nar: On the b | asis of exan | Ination an | d/or Inve | estigation | , in my or | oinlon, dee | th occurr | ed at the time | , date and | d placa, | and due to | the caus | se(s) |
| withi To th | Σ | 29b. Signature and title of centi | fier / | - | | | | 290 | c. License | | | | | 1 | Month, D | | |
| _ | | 1/1/01 | 4 | 11 | | | | | DA | 180 | 13 | 1 | 8 | /21 | 197 | | |
| 10 | | 30. Neme end eddress of person | on who co | mpleted caus | se of deeth (| Item 23a) (| Туре, Р | Print) | | | | ., | | 1 | | | |
| 10 | | Charles v | 3, 5 | Tilvia | The same of the sa | MU | | | PRI | nc | 100 6 | E. CARPAI | 51 | SALI | Shiry | , mo | 2101 |
| Sta | te | 31. Dete filed (Month, Dey, Yes | | 1 32 F | Registrar's S | igneture | | | | | | | | | | | |

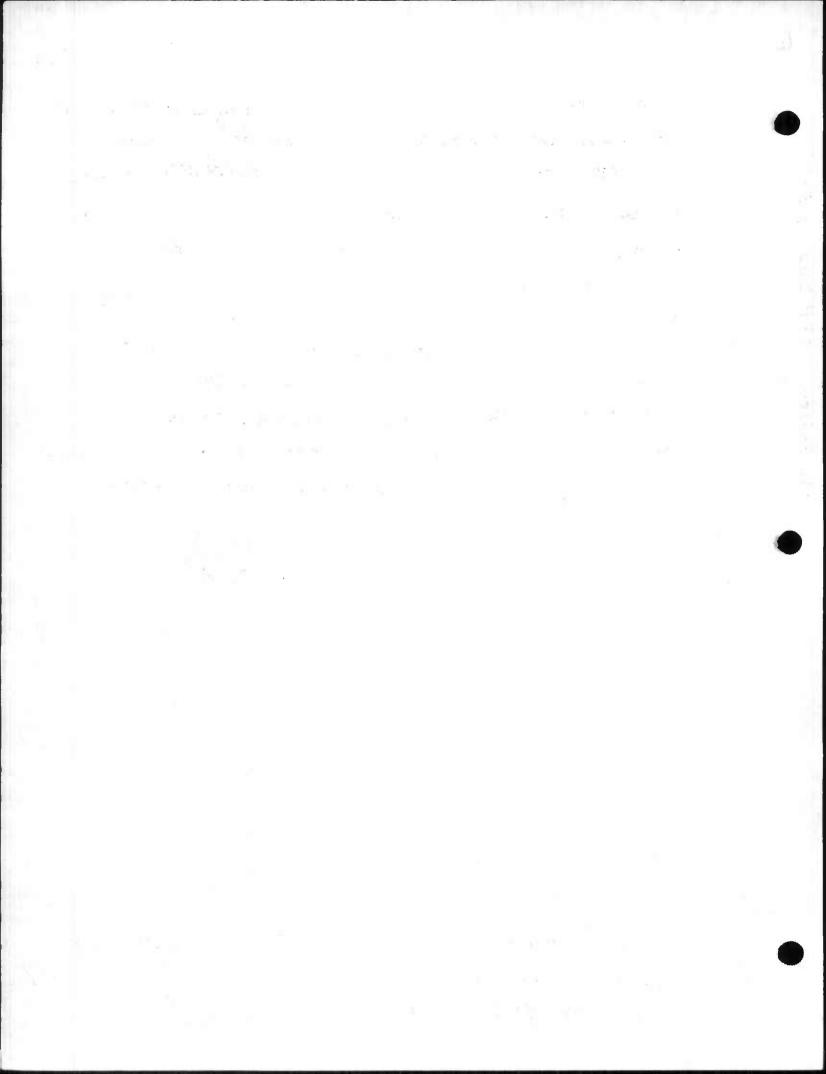
SS# 222-12-5425

Division of Vital Records, P.O. Box 68760,

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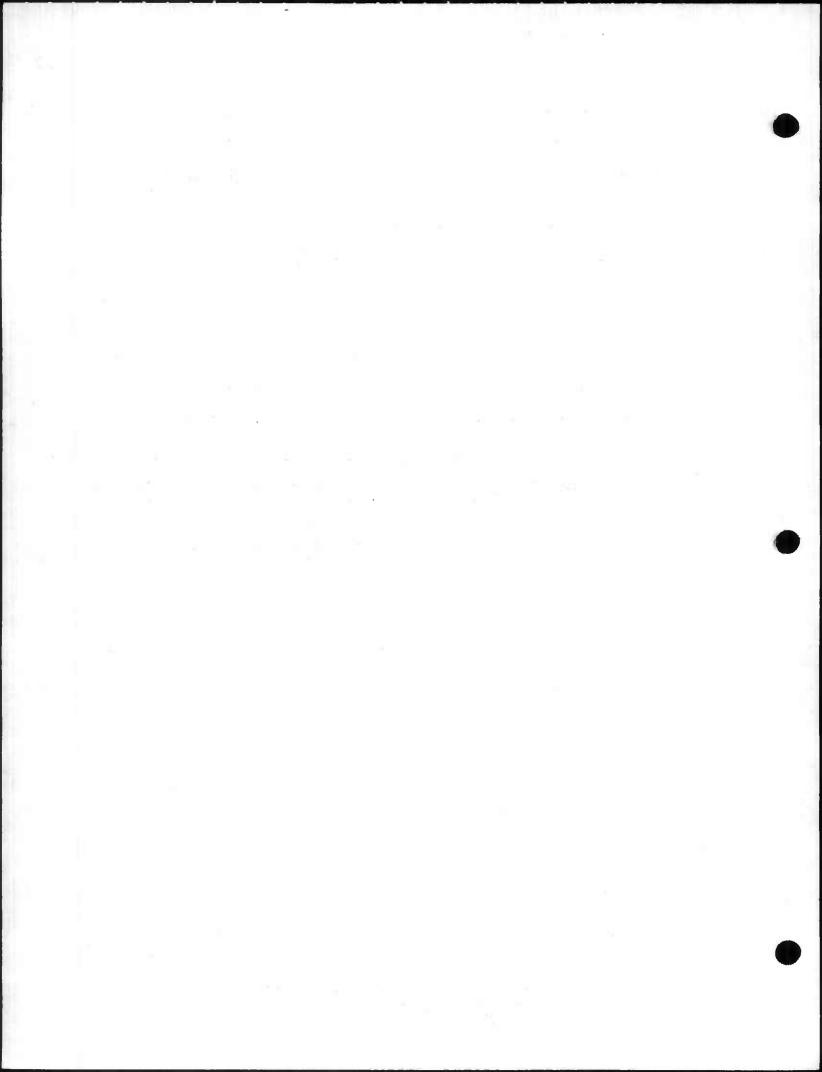
State of Maryland / Department of Health and Mental Hygiene

| | | | | State | of Marylai | | artment of I | | nd Mental H | ygiene Reg. No. | 97 | 27024 |
|-----------|--|---------------|---|-----------------------------------|--|----------------------------------|--|--------------------------------|--|-------------------------------|----------------|---|
| | Physici | ion | 1. Decedent's Neme (First, Middle, Las | , | 7 | | | | 2. Dete of D | | Yeer | 3. Time of Deeth |
| ų. | /Medi | | JOHN F. | BAILEY | | | | | Acegu | Lat 18" | 1997 | 1107 |
| | Examir | ner | 4e. Facility Neme (If not Institution, give | | | i Numero | | • | m, or Location of Dee | | nty of Deeth | |
| _ | S | H | PENINSULA REGION 5. Sociel Security Number 6. So | | 7. Age (In yrs | | If Under 1 Year | | ISBURY 4 Hrs. 8. Dete of B | | WICOMI | |
| | Funeral Director | | | JM 2□F | 47 | Yrs. | Months Days | Hours | Min. SEPT. 30 | 3, 1927 | | lece (Stete or Foreign try) AWARE |
| | P . | | Usuel Residence of Decedent 10e. Stete 10b. County | | 40-0 | | | | | | | |
| | /enyla | ō | DELAWARE SUSSEX | ζ. | i i | ity, Town or Lo [LLSBOR | | | | | 1 | 0d. Inside City Limits 1X Yes 2 □ No |
| | h the Merylan r 28a-f ahow inotified at | Director | 10e. Street end Number | | | | 10f. Zip Code | | | 10g. Citizen | of Whet Coun | |
| | deeth with the Meryland ms 23a or 28a-f ahow rmant be notified at | | 28 HUB COURT | | | | 19966 | | | USA | | |
| | Items Iner ma | Funeral | 11. Meritel Status | 12. Wes Dec | edent Ever in U | J,S. 13. | Was Decedent of it | lispenic Origi an, Mexicen, | in? (Specify Yes or N Puerto Rican, etc.) | lo- 14. F | tece - Americ | |
| 20 | within 72 hours after ene. than "natural", or ite | by F | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 130 Yes ItAYes, G Yeer or I | 2 No | | 1□Yes 2√□No | Specify: | | | city: WHI | |
| 1215-0020 | 2 hou | | 15. Decedent's Ed | ucetion | 1944- | 16e. Dece | dent's Usuel Occup | pation | , | | Business/Inc | |
| 717 | thin 7. | Completed | (Specify only highest green Elementary/Secondery (0-12) | | (1-4or 5+) | (Give | kind of work done DO NOT use retire | during most (d) | of working | | | |
| N | led wi lygien her th | | 12 | | | TILE | CONTRACT | | | | RACTING | j |
| and | d be fi | o Be | 17. Fether's Neme (First, Middle, Last) HOWARD F. BAIL | ΞY | | | | 18. Mother | 's Neme (First, Middle A L. COP) | | eme) | |
| ary | should nd Men marks umatic | F | 19e. Informent's Neme/Reletionship (7 | ype, Print) | | 19b. Maili | ng Address (Street | end Number | or Rurel Route Num | ber, City or Tox | vn. Stete. Zip | Code) |
| , Ma | and 2 salth a 1.27 is | | MABEL BAILEY | (WIFI | Ξ) | | | | BORO, DE | | | |
| ore | ges i t of He If Item or oth | | 20e. Method of Disposition 1 Buriel 2 Cremetion 3 | Removei from | | cemetery, crei | sition (Neme of metory or other ple | ce) | Dete | 1 | n - City or To | |
| Saltimor | Pa ant: ury | | 4 ☐ Donation 5 ☐ Other (Specify | | (| | LOWS CÉM | | 8-22-19 |)/ MIL | TON, D | ELAWARE |
| pa | Departi Departi Importi any Inj once. | | 21. Signeture of Funeral Service Licens Leanse M. Mu | 1 | | 5 | SHORT FUN | ERAL S | SERVICES, | 416 FED | ERAL S | Т. |
| | 13000 | | 23a. Pert1. Enter the disease, or comp shock, or heart feilure. List only | | ceused the dea | th. Do not ent | ATLTON, D er the mode of dyir | ng, such es c | erdiac or respiretory | errest, | | Approximete Intervel Between |
| | Physician /Medical | | | 1 | of to | Inn | | 1.0 | 1 T. 1. | with | | Onset end Deeth |
| | Examiner | | Immediete Cause (Finel diseese or condition resulting in deeth) | 1 | cina | ,000 | 10 CAN | BIL | Cuyg1 | w Cr4 | n | dry |
| | | Jer | | 1 | V C | oras a consec | quence of): | te | 4 /2- | | 0 | / |
| | cete be executed physicien end it the buriel-transit | Examiner | Sequentially list conditions, | 6 | Due to (| or as a consec | juenge of): | , | 1 100 | ers | | |
| 9/00, | be exe icien e buriel | ai E | Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury | 0. | | | | / | | | | |
| 200 | _ 07 | edicai | thet initieted events resulting in deeth) Lest | | Due to (d | or as a conseq | uence of): | | | | 1 | |
| × | leath certific ettending p | Physician/M | | d | | | | | | | - | |
| . 0 | 0 0 2 1 | sicie | Pert II. Other significant conditions co | ntributing to d | eath but not res | uiting in the u | nderlying cause giv | ren in Pert i. | 23b. Dic | tobacco use | contributs to | the cause of death? |
| | The law requires thet the death ate hes been signed by the etter page 2 should be deteched for | | | | | | | | 16 | 2 N | 3 Prob | ably 4 Unknown |
| Sp. O | signe signe | d by | | | | | | | 24a Wa | | 24h We | re eutopsy findings |
| 3 | w require been si should | lete | | | | | | | per per | s en eutopsy formed? | COL | alleble prior to inpletion of cause |
| ב | sician: The law s certificate hes b lirector, page 2 s | Completed | | | | | | | 10 | Yes 2 DNo | | leath? |
| | ysician: The last certificate he director, page | Be C | 25. Wes case referred to medical exeminer? | | | | | 26. Place o | of Deeth (Check only | | | 20340 |
| 5 | hysic his ce al dire | 2 | 1 Yes 2 Ne | | Impatient 2 | ER/Outpetien | | 4 LI Nurs | sing Home 5 - Res | idence 8 🗆 0 | ther (Specify | ') |
| 5 | After funer | lon | 27. Menner of Deeth 1 ☐ Maturel 5 ☐ Pending | 28e. Dete (Mon | of Injury th, Dey Year) | 28b. Time of Injury | Wor | yet k? Yes 2∐No | | how Injury occ | urred | |
| 2 | Atten r deet ctor: by the | ertification: | 2 Accident Investigation 3 Suicide 8 Could not be determined | 28e. Piece | of Injury - At h | ome, ferm, str | eet, fectory, office | 165 2 140 | | (Street end Nu | mber or Rure | Route Number, |
| 5 | s effe | Cert | 4 Homicide | buildi | ing, etc. (Specif | y) | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | City or To | iwn, Stete) | | |
| | To the Hospital or Attending Physician: in 24 hours stert death. To the Funeral Director: After this certifica completely filled in by the funeral director. | edicai (| 29a. Certifier (Check only one) 1 Certifying Physical Examination | ner: On the b | best of my kno esis of exemina ner stated. | wledge, deeth tion end/or Inv | occurred et the ting restigetion, in my o | ne, dete end pinion, deeth | plece, end due to the occurred et the time | ceuse(s) and dete end plec | menner es st | ated. the ceuse(s) |
| | within To the | ¥ S | 29b. Signeture and title of certifier | and men | iiii sialed. | | 29c. Licens | e number | CI | 29d. Date sig | ned (Month, L | Day, Year) |
| | | | | - | > | | D | 367 | 83 | 81 | 18/ | 97 |
| , | 6 | | 30. Name and address of berson who co | mpleted ceus | se of deeth (Item | n 23a) (Type, | Print) DA | enc | , SALTS | Buny | int | 21804 |
| | Stat Registra | | 31. Dete filed (Month, Dey, Year) AUG 2 2 1997 | 32. R | egistrer's Signe | Randall | 1 | / | | 1 | 1 | |
| | | | TOUR R 1991 | 11 | | | | | | | | |



State of Maryland / Department of Health and Mental Hygiene 97 27025

| | | | | | | | Ce | ertificat | e of | Deatr | 7 | | Reg. N | lo. | | |
|--|----------------|--|---|---------------------------|---|--|--|--------------------------|----------------|-------------|-------------------|---------------------------------------|--------------------|------------------|------------|---|
| Physic | ian | 1. Decedent's Neme | | | | | | | | | | 2. Dete of D Month | | өу | Year | 3. Time of Deeth |
| /Med | | Estelle | | | | | | | | | | August | | | 997 | 10:59 AN |
| Exami | iner | 4e. Fecility Neme (If n | | | | r) | | | | | | ocation of Dee | th 4 | c. Count | | |
| | , 1 | | | s Hos | | | | | | | nardt | | | | | ry's |
| Funera | _ | 5. Social Security Nur | | 6. Sex 1 ☐ M | | ge (In yrs. | last birthde; Yrs. | Months | 1 Year Deys | | r 24 Hrs. Min. | 8. Dete of Bi (Month, D July 2. | rth ey, Yes | " | 9. Birth | plece (Stete or Fore |
| Director | | 214-28-75 Usuel Residence of D | | | | 76 | | | L. | | | July 2 | 2,15 | 121 | Mar | yland |
| land | | | 0b. County | | | 10c. City | y, Town or I | ocation | | | | | | | | 10d. Inside City Lim |
| Many | ō | MD | St | Mary' | c | C | alifo | rnia | | | | | | | | 1 ☐ Yes 2 📉 |
| 28a | Director | 10e. Street end Numb | | mary . | | | alito | 10f. Zig | Code | | | | 10g. (| itizen of | Whet Co | untry? |
| 3a o | 0 | 46111 Rag | boows | Lane. | P.O.B | lox 30 | 2 | | 20 | 619 | | | | ISA | | |
| ms 2 | Funeral | 11. Maritei Stetus | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | es Deceden | | | . Wes Dece | | | rigin? (Sp | ecify Yes or N Rican, etc.) | | 14. Re | | ican Indian, |
| far far | F | 1 Never Married | 2 X Merr | ied 1 | Yes 2 | | | | | | | Rican, etc.) | | Ble | ck, White | , etc. |
| air, o | by | 3 ☐ Widowed 4 | Divorced | lf Y | Yes, Give eer or Detes | : | | 1 🗆 Yes | 2 🖾 No | Specify | <i>/</i> ; | | | Specif | b: B1 | ack |
| 2 ho | Completed | 15-0-15 | 5. Decedent | 's Education |) | | 16e. Dec | edent's Usu | el Occu | petion | na od cood | · la a | 16b. | Kind of B | usiness/l | ndustry |
| Ban " | ple | Elementery/Second | | t grade com | ollege (1-4or | 5+) | life. | o kind of wo DO NOT u | se retire | during mo | St of Work | ing | | | | |
| gien gien | No. | 8th | | | | | | Home | nake | r | | | | Own | Home | |
| othy | Be (| 17. Fether's Neme (Fi | rst, Middle, | Last) | | | | | | 18. Moth | er's Nem | e (First, Middle | , Maid | an Sumer | ne) | |
| permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Heelth and Mentel Hygiene. Important: If them 27 is marked other than "natural; or items 23a or 28e-f show any injury or other traumatic avent, the Medical Exemination nothing at angles. | To | James | Buste | r Mil | ls | | | | | | De | 11a | | Th | omas | |
| am a | ľ | 19e. Informent's Nem | e/Reietionsl | hip (Type, P | nint) | | 19b. Ma | ling Address | (Street | end Numb | ber or Rur | al Route Numi | ber, City | or Town | , Stete, Z | ip Code) |
| elth 27 i | | Charles H | lenry | Bennet | tt/Hus | band | P.0 | .Box | 302, | Cali | forn | ia, MD | 206 | 19 | | |
| of He off | | 20e. Method of Dispos | | | | | lece of Disp | oosition (Nei | me of | ice) | | Dete | 20c. | Location | - City or | Town, Stete |
| Page nent of mt: M | | 1 🖾 Buriel 2 🗔 6 | | | rel from Stete | Ð | | - | | | arv | 8/7/97 | Lex | ingt | on P | ark, MD |
| orta orta | | 21. Signigure of Fune | ral Service I | Licenseq/ | 20 | 1 | | _ | | | | | | - | | |
| Depar Impor any ir | | much | 07 | 29 | 2 | | | | | | | r Fune: | | | | Α. |
| _ | | 23s Pert 1 Enter the | disease or | complication | s that cause | d the deeth | | | | | | rdtown | | 206 | 50 | Approximate |
| | | 23a Pert 1 Enter the shock or heart f | eilure. List | only one cel | use on eech | line. | | | ,. | | | | | | 1 | Interval Between Onset and Death |
| Physician /Medicai | | Immediete Ceuse (Fir | nel | | | | | | | 4.5 | | | | | | |
| Examiner | | diseese or condition resulting in deeth) | 070 | θ | Co | rona | 174 | a (te () | 4 | di se | ase | | | | | about 5 ye |
| | ē | | | | 0 | Due to (o | res d cons | equence of): | | | | | | | | |
| nsit | Examiner | | | b | 661 | | | | | iccid | ent | - | | | i | one year |
| certificate be executed nding physician end usa as the burial-transit | Exa | Sequentielly list cond if eny, leeding to immo cause. Enter Underly Ceuse (Diseese or Inj that initiated events resulting in deeth) Les | itions, ediate | | 0 | | | equence of): | | | | | | | 1 | |
| sicia bur | | Ceuse (Diseese or Inj | ury | C | 76 | | | Sord | 40 | | | | | | | meyen |
| ficat phy is th | n/Medical | resulting in deeth) Les | st | | | Due to (or | es a conse | equence of): | | | | | | | | |
| nding usa s | M | | 1 | d | | | | | | | | | | | | |
| atte 1 for | Physician | Don't Other standing | | | | | Maria de la compansión de | | | | | l ook mi | | | | |
| y the | ys | Pert II. Other aignifica | int conditio | ns contribut | ing to deeth | but not resu | ilting in the | underlying o | ause gh | ven in Pert | 1. | | | | | to the cause of dea |
| that ed b deta | P | | | | | | | | | | | 16 | Yes | 2 □ No | 3∐ Pr | obebly 4 Unkn |
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| pe Deen | ete | | | | | | | | | | | perf | ormed? | opsy | 6 | veilable prior to ompletion of cause |
| has l | Completed | | | | | | | | | | | | | | 0 | f death? |
| Cata peg | | | | | | | | | | | 2.0 | 10 | Yes | 2 No | 1 | ☐ Yes 2☐ No |
| clan | Be | 25. Wes case referred exeminer? | to medical | | | | | | 1 | | e of Deat | h (Check only | one) | | | |
| hysic his c | 2 | 1 ☐ Yes 2 No |) | Hospite | 1 M Inpat | lent 2 🗆 | | | JA | | - | me 5 Res | | | | eity) |
| To the Hospital or Attanding Physician: The li within 24 hours offar death. To the Funeral Director: After this certificata has completely filled in by the funeral director, page | Certification: | 27. Menner of Deeth | 5 🗌 Pending | 286 | e. Dete of Inj (Month, D | ury e <i>y Year)</i> | 28b. Time Injury | | 8c. Inju Wo | | | 28d. Describe | how in | ury occur | rred | |
| eath or: A | cat | 2 Accident | investig | | | | | М | 1 🗆 | Yes 2□ | | | | | | |
| frar direct | 듣 | 4 Homicide | determi | | Plece of in building, e | njury - At ho itc. <i>(Specif</i> y | me, term, s | treet, fector | , offica | | | 281. Location City or To | (Street wn, Ste | and Numi ite) | ber or Ru | ral Route Number, |
| ital c | | | | | | | | | | | | | | | | |
| Hosp 4 hou Fune ely fi | edical | (Check only 2 | Certifying | Physician: Examiner: O | To the best | of my know | viedge, dee | th occurred | et the ti | me, dete e | nd piace, | and due to the | cause date e | s) and m | enner as | stated. to the cause(s) |
| To the I within 2 To the I complet | Med | onej | | Θι | nd manner s | teted. | | | | | | | | | | |
| 5 × 5 % | 5 | 29b. Signature end titl | e of certifier | | | | | | | se number | | | 29d. C | ete signe | d (Month | , Day, Year) |
| | | P (() | June | (p | R-M-A | . Ray | may. | (94 | D 5 | 0041 | 4 | | (| 08/0 | 4/9 | 7- |
| | | 30. Neme end eddress | of person v | - | | | | | | | | | | 1 | | |
| | | MOHAMMAI | RAHM | IAN M. | D. | | L.E.C | NARDT | OWN | MD ' | 20650 |) | | | | |
| Sta | ate | 31. Dete filed (Month, | Dey, Yeer) | | 32. Regist | rar's Signat | ure o | 0 .4 | ~**** , | 1 6 8 8 P W | | | | | | |
| Regist | rar | | AUG | 7 199 | Mal | ia althus | please No | rdall | | | | | | | | |
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State of Maryland / Department of Health and Mental Hygiene

27026 Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** Day I8 Marian 9:55 PM. Loretta Barton August /Medicai 4e. Fecility Nama (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner St. Mary's Hospital Leonardtown St. Mary 5. Social Security Number If Under 1 Year | if Under 24 Hrs. 7. Age (In yrs. iest birthday) Birthpleca (State or Foreign Country) **Funeral** 8. Dete of Birth (Month, Dey, Yeer) 1□ M 201 F Months Days 292-20-8798 79 Yrs. Director July 17,1918 Greenville, PA Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours efter death with the Meryland neat of Heelth and Mental Hyglene.
Int: If Itam 27 is marked other than "naturst", or items 23s or 28s-f show any or other traumatic event, the Medical Exerciter must be notified at any or other traumatic event, the Medical Exerciter must be notified at 10e. Stete 10b. County 10c. City, Town or Location 10d. insida City Limits 1 ☐ Yas 2 X No Director MD St. Mary Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21120 Ace Way 20653 Funeral USA 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Dates: Wes Decedent of Hispanic Orlgin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Rece - American Indian, Bleck, White, etc. 11. Meritel Stetus 1 Never Merriad 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Be Completed by Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) Collaga (1-4or 5+) Bowling Alley Cook 17 Fether's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Albert Willis Foltz Bertha May Lilley 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Gordon R. Upchurch/Son 21120 Ace Way, Lexington Park, MD 20653 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20e. Mathod of Disposition 20c. Location - City or Town, Stete 1 Burial 2 XCrametion 3 Removal from Stete Depertment of Important: If any injury or 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitian Crematory 8/20/97 Alexandria, VA 21. Signature of Funerel Service Licentee 22. Neme end Address of Fecility Mattingley-Gardiner Funeral Home, P.A. P.O.Box 270, Leonardtown, MD 20650 Entar the disease, or complications thet caused tha deeth. Do not antar the mode of dying, such es cardiac or respiretory errest, or haart failure. List only one ceuse on each lina. Approximate Interval Between Onset and Death Physician Immediete Causa (Final diseese or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed the buriel-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events rasulting in deeth) Lest Due to (or as e consequence of): MARIAN LORETTA BARTON Division of Vital Records, P.O. Box 68760, ettending physician Due to (or as a consequence of): for use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by t Yes 2 No 3 Probably 4 Unknown ģ 24b. Wara autopsy findings available prior to completion of causa of deeth? director, page 2 should Completed 24a. Was an autopsy performed? 1 Yes 2 J.H Be 25. Wes case raferred to medical examiner? 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1□ Yes Inpatient Certification: To 2 ER/Outpetient 3 DOA nours efter death.

neral Director: After this
filled in by the funeral di After this 27. Menner of Deeth Dete of injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred 1 Maturel 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, ferm, straet, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital or within 24 hours of To the Funeral Di Medical Decritying Physician: To the best of my knowledge, deeth occurred et the time, deta end piece, and due to the causa(s) end menner es stated.

| Medical Examiner: On the basis of axamination end/or investigetion, in my opinion, deeth occurred at the time, dete end piace, and due to the causa(s) and menner stated. 29a. Certifier (Check only one) 29b. Signature and title of ceatier 29c, Licanse number 29d. Deta signed (Month, Dey, Year) 30. Name and address of person with led causa of daath (Itam 23a) (Type, Print) LEONARDTOWN, MD. 20650 JAMES BOYD M.D. Date filed (Month, Day, Year) AUG 20 32. Registrer's Signature State Lin Stewelson Randall 199 Registrar

DHMH 16 Rev 6/95

August 26,1997 Branham Baltimore, Maryland lerbert

21215-0020

that the death certificate be axecuted

P.O. Box 68760.

Records,

Division of Vital

the Maryland

1. Decedant's Name (First, Middla, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** August 26, 1997 6:24 a.m. Hoover /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Charlotte Hall Veterans' Home Charlotte Hall St. Mary's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Yaer) April 26,1929 Birthplece (Stete or Foreign Country)
 Virginia 7. Age (In yrs. lest birthdey) **Funeral** 1 M 2 F Months Deys Hours Yrs. Director 217-26-2182 68 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be nothed at Director 1 ☐ Yes 2 ■ No Maryland St. Mary's Charlotte Hall 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 29449 Charlotte Hall Road 20622 United States 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 1 ■ Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ■ No Spacify: Specify: White þ 3 Widowed 4 Divorced WW2 Completed 15. Decedent's Education (Specify only highest grade complated) 16e. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry filed within 7 Hygiene. Elamentery/Secondary (0-12) Collaga (1-4or 5+) Cook Food Service Alth end Mentel Hw 17. Fethar's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Maidan Sumama) Schyler Branham Meallie Johns 19a. Informent's Neme/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) permit. Pages 1 and 2: Department of Health er Important: If item 27 is any Injury or other trau 3230 Normandy Woods Drive, Apartment A, Ellicot City, MD 21043 Flo Ann Allen, Niece 20e. Method of Disposition 20b. Pleca of Disposition (Nema of cematary, cremetory or other plece) Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ■ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 8-27-1997 Alexandria, Virginia Metropolitan Crematory 22. Name end Address of Fecility

Brinsfield Funeral Home, P.A. Michael K. Blankenship, MOO857 22955 Hollywood Road, Leonardtown, Maryland 20650-0279 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cerdiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete fntervel Batween Onset end Deeth **Physician** Immediate Ceuse (Finel diseese or condition rasulting in deeth) /Medical CARCINOMA OF THE LUNG Examiner Examiner burial-transit Sequantielly list conditions, if eny, leading to immediata cause. Enter Underlying Causa (Diseese or Injury that initieted events resulting in death) Lest and Due to (or es a consaguence of) Physician/Medicai the Due to (or as e consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 CHRONIC DESTRUCTIVE LUNB 1 No 3 Probably 4 Unknown signed b þ 24b. Were eutopsy findings evellable prior to completion of ceuse of daeth? Completed 24a. Wes en eutopsy 1 ☐ Yes 2 XNo 1 Tyes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funers! Director: After this certification platally filled in by the funeral director; prompletally filled in by the funeral director; promplet 25. Was cese rafarred to medical examinar?
1 Yes 2 No Be 26. Placa of Death (Check only ona) Hospitel: Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA edicai Certification: To 27. Mannar of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Dascribe how Injury occurred 1 Natural 5 Panding Investigation 1 Yas 2 No 2 Accidant 6 Could not be datarminad 3 Suicida 28a. Pleca of Injury - At homa, farm, street, factory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Phyeicien: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, death occurred at the time, dete end place, end due to the cause(s) end menner steted. 29e. Certifiar 29b. Signeture end title of or 29c. License number 29d. Dete signed (Month, Day, Yeer) 30. Nama end addrass of parson eted causa of daeth (Itam 23a) (Type, Print) #602 Wood LINTON, MO

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

27027

DHMH 16 Rev 6/95

State

Registrar

31. Deta filed (Month, Dey, Yaar)

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Gr.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Deeth **Physician** Month 8.45 am BLANCHE LUCILE Augusi 1997 26. /Medical 4e. Fecility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** SOUTHERN CLINTON PHINCE GROWLES MAZZIAND HOSPITAL If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

OCTUBER 5, 7. Age (In yrs. last birthday) 86 Yrs. 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1□M 20 F Months 1910 MARYLAND Director 219-36-8623 Usual Residence of Decedent death with the Marylend 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits ahow 7 is marked other than "natural", or items 23s or 28s-f abor traumstic avant, the Medical Examiner must be notified at 1 Yes 2 No Director MARYLAND WALDORF CHARLES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 6084-A THOROBRED COURT 20603 Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Hebith and Mental hygiene. Important: if fem 27 is merked other than any injury or other traumment. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) BOARD OF EDUCATION PROFESSOR/EDUCATOR 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumame) **BLANCHE GARNER** HARRY CLAY BOWIE, SR. 19e. Informant'a Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 52, LaPLATA, MARYLAND 20646 IRENE B. WOOD/SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removel from State
4 Donation 5 Other (Specify) **REST CEMETERY** AUG.29,1997 LaPLATA, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
THE HUNTT FUNERAL HOME, INC. M00053 MARK G. BROHAWN 20604 P.O. BOX 156, WALDORF, MARYLAND 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, auch as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** ABDOMINAL ANEURYSM /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner physician and the buriel-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical 98 ettending (signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 €Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? been si 24a. Wes an autopsy performed? Completed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1₽Inpatient 2□ER/Outpetient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Naturai 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 290. Signature and title of certifier 29d. Dete signed (Marsh, Day, Year) and address of person who completed cause of death (item 23a) (Type, Print) ANNETTE 20602 GONSALVES 6. POST OFFICE Rd NaLDORF MD 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature

Achi Davidson Rendall

DHMH 16 Rev 6/95

State

Registrar

AUG 2 8 199



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Daath 3. Tima of Death **Physician** Month Yaar Anna Margaret Bishton 1997 2:15 p.m. 19 /Medical August 4c. County of Death 4a. Facility Nama (If not institution, giva street and numbar) 4b. City, Town, or Location of Daath Examiner 315 Rosin Drive Queen Annes 5. Social Sacurity Numbar 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Days 1 M 200F 81 Yrs 107-01-7675 Director April 6, 1916 New York Usuai Rasidanca of Dacadant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits "natural", or items 23s or 28s-f show edical Exeminer axist be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Queen Annes Chestertown 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 315 Rosin Drive 21620 U.S.A. death 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No if Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Exemp 1 Navar Marriad Marriad Baltimore, Maryland 21215-0020 1 Yas 2X No Specify: White þ Specify: 3 ☐ Widowad 4 ☐ Divorcad Completed 15. Decedent's Education (Specify only highast grada complated) 16e. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elemantery/Sacondary (0-12) College (1-4or 5+) Florist Floral/Greenhouse 17. Fathar's Name (First, Middla, Last) 18. Mothar's Neme (First, Middla, Maidan Surnama) Be Eugene Penner Anna Caroline Guggeis 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda2162019a. Informant's Name/Reletionship (Type, Print) Harry Bishton/Husband 315 Rosin Drive, Chestertown, Maryland 20b. Placa of Disposition (Name of camatary, cramatory or other place) August 23, 1 997 20a. Mathod of Disposition Communication 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) St. Pauls Cemetery Chestertown, Maryland 21. Signature of Foheral Service Licensee 22. Nama and Addrass of Facility Fellows, Helfenbein & Newnam Funeral Home, 130 Speer Road, Chestertown, Maryland 21620 ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each line. Approximata Intarval Betw **Physician** /Medical Immediata Cause (Finel disaasa or condition rasulting in daath) MUCTIPLE MYELCOMA 2×ns Examiner Due to (or as a consequance of): Examiner burial-transit Sequantially list conditions, if any, laading to Immadiate causa. Enter Underlying Causa (Disaasa or injury that initieted evants rasulting in daath) Last pue Dua to (or es a consequança of): physician of the burial Box 68760 The law requires that the death certificate be Physician/Medical Dua to (or as a consequanca of): esn Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? á 1 Yes \$€ No 3 Probably 4 Unknown signed i by 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en autopsy parformad? Completed page 2 s certificate 1 Yas 2 No 1 Yas 2 No Division of Vital Hospital or Attending Physician:
 124 hours efter death.
 Funeral Director: After this certificaletely filled in by the funeral director; Be 25. Was casa refarred to medical 26. Placa of Daath (Check only one) 1 ☐ Yas 2 No Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Other (Specify) Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Natural 2 Accident 5 Panding invastigation 1 ☐ Yas 2 ☐ No 6 Could not be detarmined 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Pleca of Injury - At homa, farm, straat, factory, offica building, afc. (Specify) 4 Homicide 29e. Cartifier (Check only one) Certifying Physician: To the best of my knowledge, daath occurred et the tima, dete and plece, end dua to tha causa(s) end menner as steted.

| Medical Examinar: On the best of axaminetion and/or investigation, in my opinion, death occurred at the time, dete end plece, and dua to the cause(s) and mannar stated. Medical To the Hosp within 24 ho To the Fune completely fi 29b. Signatura and titla of cartifiar 29c. Licansa number 29d. Data signad (Month, Day, Year) min 30. Nema and address of person who complated cause of death (Itam 23a) (Type, Print) 6 John C. Seymour, MD, 122 Speer Road, Chestertown, Maryland 21620 31. Data filed (Month, Day, Yaar) 97 32. Ragistrer's Signatura

Julia Daudson-Randall State Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Q 7 Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Deeth 3. Time of Deeth Dey 1997 Month COVINGTON 23, Aug. 12:30 PM MAE MYRTLE MAE

4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Wicomico Salisbury, Md. Salisbury Center; Genesis ElderCare If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) 1□ M 2**X** F Days Yrs. 1910 Maryland 07 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 xes 2 No Wicomico Salisbury 10f. Zip Code 10g. Citizen of What Country? 517 Buena Vista Avenue 21804 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3€Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Homemaker None 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Cox Sr. Maggie 19a. Intormant's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 901 Vincent St., Salisbury, MD 21804 Elizabeth W. Merritt-Daughter 20b. Placa of Disposition (Neme of cametery, cremetory or other pleca) 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 8/26/97 Salisbury, MD Parsons Cemetery 22. Name and Address of Fecility Holloway Funeral Home, P.A. 21. Signeture of Funeral Service Licensee 501 Snow Hill Road, Salisbury, MD Hellow 23a. Part1. Enter the disease, or complication with call sed the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart feilure. List only one cause of seach line. Due to (or as e consequence of): Due to (or es a consequança of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings evaileble prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place ot Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 6 Could not be determined 28e. Placa of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 1 Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plece, end due to the cause(s) and manner stated.

29c. License number

D-39813

29d. Date signed (Month, Dey, Yeer)

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23e or 28a-f show any Injury or other traumatic event, it is the other traumatic event, Baltimore, Maryland 21215-0020 **Physician** /Medical Examiner physician end s the buriel-transit The law requires that the death certificete be executed

Box 68760.

P.O.

Division of Vital Records,

Hospital or Attending Physician:

After

Physiclan

/Medical

5. Social Security Number

Usual Residence of Decedent

Elementery/Secondary (0-12)

Wesley

20a. Method of Disposition

Immediate Cause (Finel disease or condition resulting in death)

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in death) Last

1 ☐ Yes 2 No

27. Manner of Deeth

1 Netural

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 - Homicide

29b. Signatura and title of certitier

6

218-14-2581

10e. Street and Number

10e. Stete

Director

Funeral

þ

Completed

Be

Examiner

Funeral

Director

Completed by Physician/Medical Examiner Certification: To within 24 hours efter death.

To the Funerel Director: All completely filled in by the fu

State Registrar

Medicai

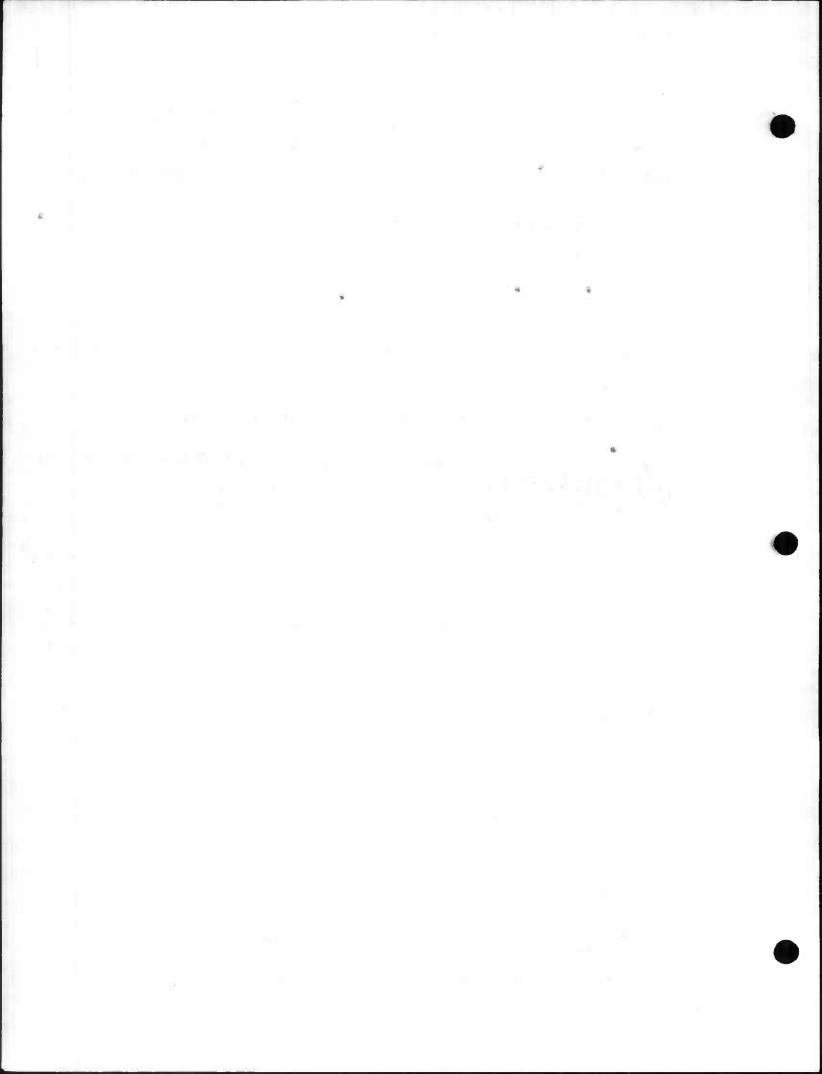
30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

MICHAEL ATKINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD. 21804

31. Dete tiled (Month, Day, Yeer) 32. Registrar's Signeture AUG 261997 Julia Davidson Rardall

| #5 | did | 8-29-97, St. Mc | | | Certificate o | | 2. Dete of D | Reg. No. | Con | 3. Time of Death |
|---|----------------|---|---|----------------------------|--|---|---|------------------------------------|---------------------------------|--|
| Physic /Med | | JOHN PER | | С | AULDER | SR. | AUGUS | Day | Yeer | 1:00a.r |
| Exam | ner | 4a. Facility Name (If not institution, | give street and number) | | | 4b. City, Town, or | Location of Dee | th 4c. County | of Death | |
| | | Calvert Memorial | | | | | Frederi | | lvert | |
| Funera Director | | 5. Social Security Number 6 248 – 50 – 7760 – 248 – 5 – 7760 Usuat Residence of Decedent | 1 M 2 F | yrs. last birtl | hday) If Under 1 Yea Months Day | | | | | ce (State or Foreig arolina |
| death with the Maryland ms 23a or 28a-f show | 2 | 10a. State 10b. County | 10c. | City, Town | or Location | | | | 100 | I. Inside City Limits |
| ha M | Director | Maryland St. N 10e. Street end Number | lary's | Lexin | gton Park | | | | | 1 ☐ Yes 2 ■ No |
| with | 급 | | | | 10f. Zip Code | | | 10g. Citizen of | | |
| eath 18 23 | Funeral | P.O. Box 1283 | 12. Was Decedent Ever is | nIIS | 2065 | | Specify Ves or N | United | e - American | |
| b 2 2 | by | 1 Never Merried 2 Married 3 Widowed 4 Divorced | Armed Forces? | | 13. Was Decedent of It Yes, specify Cu | | rto Rican, etc.) | Specify Specify | ck, White, etc | C. |
| 72 ho | ted | 15. Decedent's (Specify only highest) | Education | 16e, I | Decedent's Usual Occ | supetion | advina | 16b. Kind ot B | | |
| within Pine. | Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | | (Give kind of work dor life. DO NOT use reti | red) | жиід | m 11 | - | |
| Hygier ther th | | 12 | | | Foreman | | | Telepho | | lustry |
| S is b | To Be | 17. Fether's Name (First, Middle, La Perry Caulder | | | | 18. Mother's Ne | nme (First, Middle | , Meiden Sumen | ne) | |
| | | John P. Caulder | II Son | 115 | Meiling Address (Stre 48 Hoofbea | | | | | |
| | | 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremation 3 4 ☐ Dehation 5 ☐ Other (Spe | □Removal from State | cemetery | Disposition (Neme of c, cremetory or other p plitan Crer | | Date 8/29/97 | 20c, Location | | n, State Virginia |
| permit. Page Department Important: If any Injury or | | 11 JUL 13 04 | ensee | | 22. Name and Add Brinsfiel | d Funeral | | | | |
| _ | | Michael K. I 23a. Perti. Enter the disease, or co shock, or heert failure. List on | Blankenship | eath. Do no | 22955 Hol | Lywood Ro | oad, Leon | nardtown | | 20650 |
| Physician | | shock, or heert failure. List on | ly one cause on each line. | | | , | | | ir C | pproximate itervel Between inset and Death |
| /Medical | | Immediate Cause (Final disease or condition | PECD | FA | LURF | | | | 1 | 2 deux |
| Examiner | | resulting In deeth) | a. Due to | o (or as e co | ILURE onsequence of): | | | | | |
| D .= | liner | | b. SERSI | | | | | | 5 | Laler |
| be axecuted ician and burial-transit | Examiner | Sequentially list conditions, if any, leading to immediate | | | onsequence ot): | | | | - | |
| icata be axecu physician and s tha bunal-tra | | Sequentially list conditions, if any, teading to tmmediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events | C | ATTE | | UMENIA | 4 | | d | days |
| | edical | resulting In deeth) Last | / Due to | o (or as a co | insequence ot): | | | | | |
| hat tha death cartif ed by the attending detached for usa a | by Physician/M | | d | | - | | <u> </u> | | | |
| 0 0 0 | /sici | Part II. Other significant conditions | contributing to death but not | resulting in | the underlying cause | given in Pert t. | 23b. Dld | tobacco uee co | ntribute to th | ne cause of death |
| requires that tha een signed by th hould be detache | Ph | BILATERAL | CEREDILO \ | Ascu | MK Ara | MENT . | 1 🗆 | Yee 2□No | 3 Probal | oly 40 Unknow |
| 8 5 8 | d b | | | | 7,0 | | 240 1400 | an autonou | 24h Were | autopsy tindings |
| _ 0 0 | ete | | , | | | | perf | an autopsy ormed? | availa comp | able prior to eletion of cause |
| has has | Completed | | | | | | | | of de | |
| iclan: The cartificata rector, pag | | 25. Was case reterred to medical | | | | 00 DL 1 D | 10 | - / - | 101 | ′es 2□ No |
| Physician: this cartific ral director, | To Be | examiner? | Hospital: | ∩ EB/Out | patient 3 DOA | M | eth (Check only Home 5 Res | | or (Coories) | |
| g Phys ar this aral di | | 27. Menner of Deeth | 28a. Dete of Injury | 28b. Ti | me ot 28c. In | | | how Injury occur | | |
| ath. r: Aft | atio | 1 Naturel 5 ☐ Pending tovestigat | (Month, Dey Year |) Inj | | ork? □ Yes 2 □ No | | | | |
| al or Atte s after da i Directo d in by th | Certification: | 3 Sulcide 6 Could not 4 Homlcide determine | be 28e. Plece of Injury - A building, etc. (Spe | t home, ferr | m, street, tactory, offic | е | 281. Location (City or To | Street end Numb wn, Stete) | per or Rural R | Toute Number, |
| To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this carific complataly filled in by the funeral director, | edical C | 29a. Certifier 1 Certifying F (Check only one) 1 Medical Ext | Phyatclan: To the best of my kaminer: On the basis of exam and manner stated. | knowledge, ination and/ | death occurred et the for investigation, in my | time, date and plec opinion, deeth occ | e, end due to the urred at the time, | ceuse(s) end ma date end plece, | anner as state and due to th | ed. e cause(s) |
| withii To th | X | 29b. Signature and title of certifier | | | 1 | nse nu <i>mber</i> | | 29d. Date signe | d (Month, Da | y, Year) |
| | | ▶ matel | MD | | D 5 | 50249 | | 8/2 | 8197 | |
| | | 30. Name end address of person wh | | | | | | | 1., | |
| 0 | | Dr. Pranay | R. Patel, M. | D., I | rince Fr | rederick | , Mary | land 2 | 20678 | |
| Sta | | 31. Date tiled (Month, Day, Year) | 32. Registrar's Sig | gnature | 1.0 | | | | | |
| Regist | | AUG 291 | 997 Jahri Dhui | wa-ha | Wall | | | | | |
| HMH 16 Ray 6/9 | 5 | | / | | | | | | | |

DHMH 16 Ray 6/95



| | | | | | Cei | tificate of | Death | | Reg. No. | | |
|--|------|--|--|---|-------------------------------|---------------------------------------|--|-----------------------------|--------------------------------|--------------------------------|-------------------------------------|
| | | 1. Decedent's Name (First, Mid | idle, Last) | | | | | 2. Date of I | | | 3. Time of Deeth |
| Physician | _ | Crisanto Vil | lena Cruz | | | | | Month AUGUS'I | Day | Year 1997 | 1:21 PM |
| /Medical Examiner | | 4e. Fecility Name (If not institut | | nber) | | | 4b. City, Town, or I | - | | ty of Death | 1:21 Pr |
| Examiner | | St. Mary's Hos | | | | | Leonardt | | | Mary | |
| | _ | 5. Social Security Number | | 7. Age (In vrs. | do no bilability of | if Under 1 Year | | | | - | |
| uneral | - 1 | | 1 M 2 F | | | Months Days | | 8. Date of E | Birth Day, Year) 26,1929 | 9. Birthpl Count Philip | ace (State or Foreign) |
| irector | - 1- | 212-29-3910 Usuai Residence of Decedent | 1 | 67 | 110. | | | October | 20,1929 | Philip | pines |
| ž | - 1- | 10a. State 10b. Coun | ity | 10c. Cit | ty, Town or Lo | cation | | | | 1/ | Od. Inside City Lin |
| or 28a-f show as notified at | 5 | | , | | | | | | | 10 | 1 ☐ Yes 2 ■ |
| Pect of | 3 | Maryland St. Ma | ary's | G | reat Mi | | | | | | |
| | 5 | 10e. Street and Number | | | | 10f. Zip Code | | | 10g. Citizen o | | |
| ral ral | 9 | 21955 Barkenti | ne Court | | | 20634 | | | United | State | S |
| or items mineral m | | 11. Maritai Status | 12. Was Dece | dent Ever in U ces? | I,S. 13. V | Vas Decedent of I Yes, specify Cub | Hispanic Origin? (S ean, Mexican, Puert | pecify Yes or h | | aca - America ack, White, e | |
| S E | | 1 Never Married 2 Ma | H Vac Giv | | | ■ Yes 2□ No | | | | | |
| "natural", o | 3 | 3 ☐ Widowed 4 ☐ Divorce | ed Year or Da | ites: | | 00 | Specify Phili | ppino | Spec | ity: Brow | 'n |
| area stee | | 15. Decede | ent's Education lest grade completed) | | 16e. Deced | ent's Usuel Occup | nation | | 16b. Kind of | Business/Ind | ustry |
| nt the Medical of the | 1 | Elementary/Secondery (0-12) | | -4or 5+) | life. L | OO NOT use retire | during most of world) | King | | | |
| 5 5 | | 12 | , | | Cust | odian | | | Cleanir | ng Ser | vice |
| ovent Be | | 17. Father's Name (First, Middle | e, Last) | | | | 18. Mother's Nen | ne (First, Midd | le, Maiden Sume | me) | |
| atic ed | | Jose Cruz | | | | | Leogarda | Ville | na | | |
| To Be Com | | 19a. Informant's Neme/Relation | nship (Type, Print) | | 19b. Maijin | a Address (Street | and Number or Ru | ral Route Num | her City or Tow | n State Zin | Codel |
| transfer | | Maila C. Gale, Dau | ughter | | 21955 J | Barkentine | Court, Gre | at Mills | , Marylan | 20634 | |
| tam 27 is marked other than "natur other traumatic event, the Medical To Be Completed | 1 | 20a. Method of Disposition | | 20b. F | Pleca of Dispos | sition (Name of | | Date | 20c. Location | - City or Toy | un State |
| | | 1 ☐ Burial 2 	 Cremetion | | State | emetery, crem | atory or other pla | , L | | | | |
| jury | | 4 □ Donation 5 □ Other (| (Specify) | Meti | | Cremator | 1 | -4-1997 | Alexandr | - | |
| Important: If Itam 27 is marked other than any injury or other traumatic event, Ira Mone. To Be Comp | 1 | a grafium of your Service | Len D | > | 22. | Name and Addre | ess of Fecility Brin | sfield F | uneral Hor | ne, P.A. | |
| - a a | | Michael K. Blan | kenship, MOO | 357 | 229 | 955 Hollyw | ood Road, L | eonardto | wn, Maryla | and 2065 | 50-0279 |
| | 7 | 23a. Part . Enter the disease, a shock, or heart tailure. Lie | or complications to t ca | used the deet | | | | | | | Approximate |
| sician | | onoun, or nount tailors. Ele | or only one cause or ee | ion little. | | | | | | 1 | Interval Between Onset end Deeth |
| edicai | | Immediate Cause (Finel | | (Ares | MAC | ARRES | T | | | i | |
| miner | | disease or condition resulting in death) | a | | | | , , | | | | |
| ē | | | | Due to (o | or as a consequ | | ou Die | BASE | | | |
| mlr m | + | | b | esym | MARION | ATICIN | eny Dis | 1773 | | i | |
| sician and burial-transit | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | | Due to (o | r as a consequ | Jenca of): | WETWE | 0 | 0 | 200 | |
| | | Cause (Disease or injury | С | C 1-3V 4 | SWI C | 01221 | WELVE | 1200 | 111111 | 431= | |
| physicians the bu | | that initieted events resulting in death) Last | | Due to (o | r es e consequ | ienca of): | | | | į | |
| ding Se 8 | | | d | | | | | | | | |
| ia i | | | | | | | | | | | |
| ed by the atten detached for u | F | Part II. Other significant condit | lons contributing to dea | ath but not resi | ulting in the un | derlylng cause giv | ven in Pert I. | 23b. Die | d tobacco use c | ontribute to | the cause of dea |
| d by letac | | Hemo | PHILLA F | 7 | | | | 1 2 | Yes 2□ No | 3 Prob | ably 4 Unkn |
| 5 2 | ١. | | 1.3.01.1 | 1 | | | | | | | |
| page 2 should | | | | | | | | 24a. Wa | s an autopsy formed? | 24b. Wei | re autopsy finding |
| 2 sh | | | | | | | | | | com of d | pietion of cause eath? |
| page 2 | | | | | | | | 1 | Yes 2 No | 10 | Yes 2□ No |
| rector, page Be Co | | 25. Was case referred to medic | al | | | | ac Dian of Dani | | | | 165 20110 |
| | | examiner? 1 ☐ Yes 2 ☐ No | Hospital: | | fnn | Ott | 26. Place of Deal | | | | |
| Z = - | 2 | 7. Manner of Death | | | ER/Outpatient 28b. Time of | 3LI DOA | 4 LI Nursing Ho | | sidence 8 Ot | | 1 |
| | | 1 ☑Natural 5 ☐ Pendi | | , Day Year) | Injury | 28c. Injur Wor M 1 | | 200. 0030100 | now injury occu | 1160 | |
| After th funeral | | 2 Accident Invest 3 Suicide 6 Could | tigation | *** | | | Yes 2 No | | | | |
| | | | mined 288. Placa C | of Injury - At ho g, etc. <i>(Specif</i>) | ome, ferm, stre v) | et, factory, office | | 28t. Location City or To | (Street and Num own, Stete) | ber or Rural | Route Number, |
| | | | | | | | | | | | |
| | | | | est of my know | wiedge, deeth | occurred et the tir | ne, date and piece, | end due to the | e cause(s) end m | anner as sta | ited. |
| | 2 | 29e. Certifier 1 Certifyi | ing Physician: To the b | | HOLL WILLY OL BLIAS | sanganon, in my o | pinion, death occur | ied et tue time | , date and pieca | , and due to t | ine cause(s) |
| | 2 | 29e. Certifier 1 Certifyi (Check only one) 1 Medical | ing Physician: To the b I Examiner: On the bas end manne | or steted. | | | | | | | |
| el Director. led in by the Certificat | | Check only 2 Medica | end manne | er steted. | | 29c. Licens | e number | | 29d. Date sign | ed (Month, D | ay, Year) |
| | | one) 2 Medica | end manne | er steted. | mp | | e number 3 9 6 0 5 | | 29d. Date sign | ed (Month, D | ay, Year) |
| | 2 | (c) | er Ly On the basend manner er | er steted. | mp | 29c. Licens | 39605 | | 29d. Date sign | ed (Month, D | ay, Year) |
| | 2 | 19b. Signeture and title of certific | er Ly On the basend manner er | er steted. | mp | 29c. Licens | 39605 | 1 1 | 8/3 | 197 | |
| | 3 | 19b. Signeture and title of certific | er Ly On the basend manner er | er steted. | mp | 29c. Licens | to SPITAL | LX | 29d. Date sign. 8/3, | 197 | |

State of Maryland / Department of Health and Mental Hygiene 27033 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Month VIOLA AUGUSTA CARROLL August 16, 1997 7:00 a.m. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Center Leanardtown St. Mary's 5. Social Security Number if Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 ■ F Yrs Director 87 578-84-9021 May 17, 1910 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f ahow other traumatic event, the Medical Examinar must be notified at 1 ■ Yas 2 □ No Director Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Route 1 Box 192 20653 United States death v Funeral Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or fren any injury or other traumatic avant 1 Never Married 2 Married 1 ☐ Yes 2 ■ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ■ No þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedant's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) N/A House Wife 8 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 0 Edward Leo Ridgell Julia Ada Peop 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Vallandingham 48724 Curley Road, Ridge, Maryland 20680 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify)

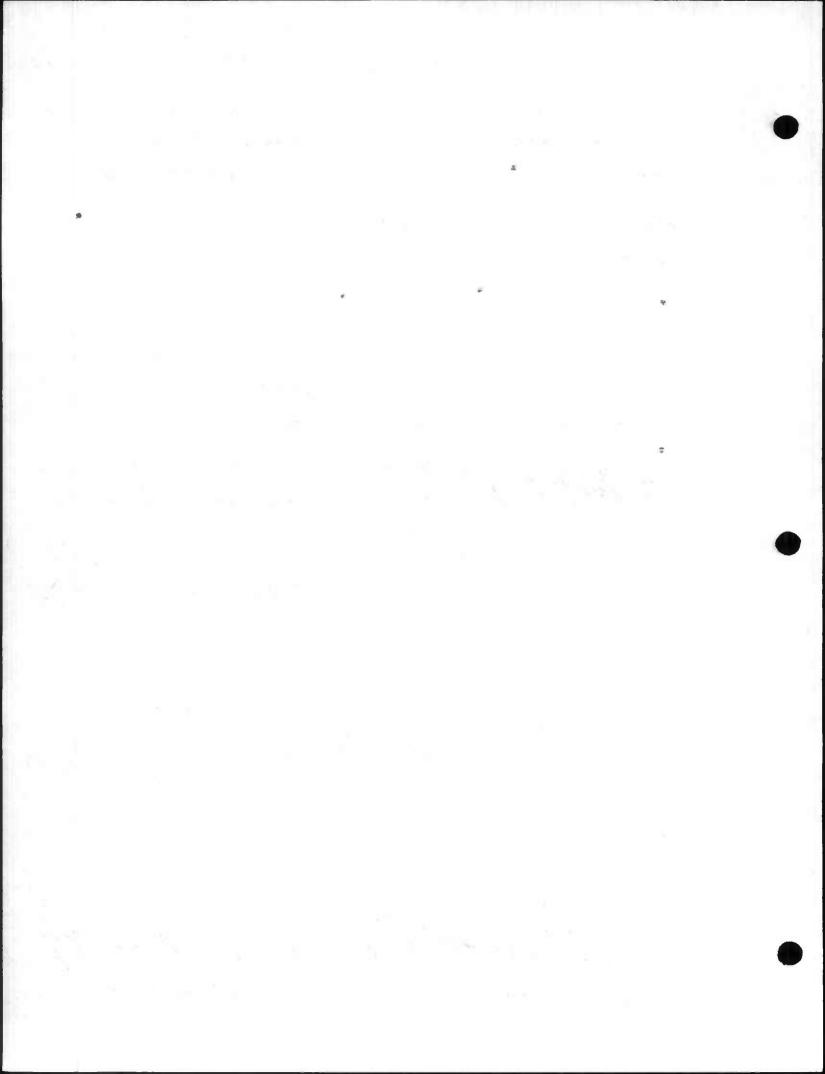
21. Signature Fundation Service University St./James Cemetery 8/19/97 Lexington Park, Maryland 22. Name and Address of Facility Brinsfield Funeral Home P.A. Brinsfield, Jr. 22955 Hollywood Road, Leonardtown, Maryland 20650-0279 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Daath Physician Immediate Cause (Finel disease or condition resulting to death) /Medical Examiner Examiner physician and the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet Initiated events resulting in death) Last Box 68760 Physician/Medical Due to (or as a consequence of): use P.O. Part II. Other significant conditions contributing to/death but of receiving the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the signed by 1 Yes 2 100 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy findings available prior to completion of osusa of death? 24a. Was an autopsy performed? Completed peed 20 No certificate 1 Yes 217 1 Yes Hospital or Attending Physician:
 24 hours efter death.
 Funeral Director: After this certifica 25. Was cese referred to medical exeminer? Be 26. Place of Death (Check only one) Other: 4 Housing Home 5 Pesidence 6 Other (Specify) Hospital: ٩ 1 Yes 2 N 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Magner of Deeth 28d. Describe how injury occurred 28b. Time of Certification: 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending Investigation 1 Z Natural 2 Accident 1□Yes 2□No 6 Could not be determined 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, straet, factory, offica building, etc. (Specify) 4 ☐ Homicide 29a. Certifier Settifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

20 Medical Examination the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the Medical On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end piece, and due to the ceuse(s) and mannar stated. (Check only one) within 2 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Yası apleted ceuse of deeth (Item 23e) (Type, Print) 30. Name and address person M.D. 22650 Cedar Lane Court, Leonardtown, MD 20650 Jarbøe,

Redistrar's Signature

DHMH 16 Rev 6/95

State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month **Physician** BETTIE LEE CHANEY 26, 1997 9:25 a.m. August /Medical 4a. Facility Name (If not institution, giva straat and numbar) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Western Maryland Hospital Center Hagerstown Washington 8. Date of Birth (Month, Day, Year)
Dec. 22, 1922 If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funerai** 1□ M 2□XF Days Hours 219-05-2923 74 Yrs **Director** Maryland Usual Residence of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland Washington Keedysville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 19402 Porterstown Road 21756 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementary/Sacondary (0-12) Collage (1-4or 5+) Seamstress 8 Years Clothing Manufacture 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumama) Be Howard Turner Lottie Stevens 19a. Informant's Name/Ralationship (Typa, Print) 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Shirley V. Rowe, Daughter 13824 Countryside Drive, Maugansville, MD 20b. Place of Disposition (Nama of camatary, cramatory or othar place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 ☐ Cremation 3 ☐ Removal from State Greenlawn Memorial Park 08/29/97 Williamsport, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Sti 22. Name end Address of Facility 7606 Old National Pike BAST FUNERAL HOME P. Steven Danfelt, Jr. Boonsboro, Maryland 21713 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest shock, or haart failure. List only one cause on each line. Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) a Congestive heart failure One week Due to (or as a consequence of): Renal failure One month Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or injury that initiated events resulting in daath) Last Dua to (or as a consequence of). Physician/Medical Insulin-dependent diabetes, hypertension, coronary d artery disease with history of myocardial infarction. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yae 2 ☐ No 3 ☐ Probably 4 M Unknown Respiratory failure, vent dependent. Peripheral þ 24a. Was en eutopsy performed? 24b. Ware autopsy findings aveileble prior to Completed vascular disease. Cerebrovascular accident. completion of cause of death? 1 Yes 2**X** No 1 ☐ Yes 2 ☐ No Be 25. Was cesa referred to medical 26. Place of Daath (Check only ona) axaminar? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yas 2 X No 10 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be detarminad 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida 1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Certifier Medical (Check only onel 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) on August 26, 1997 D34165 30. Name and addrass of person who completed causa of daath (Item 23a) (Type, Print) Mohammed Ali, M.D., 1500 Pennsylvania Ave., Hagerstown, Md. 21742-3194

State Registrar 31. Date filed (Month, Day, Year)

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32. Ragistrar's Signature

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death

Baltimore, Maryland 21215-0020

28a-f show

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Physician /Medical

Examiner

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page 2 cartificate

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P.O. Box 68760.

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State of Maryland / Department of Health and Mental Hygiene 97

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| Division | Attending Ph or death. ector: After th by the funeral | Certification: | 2 Accidant 5 Panding Invastigation | (Month, Day Year) | Injury | 28c. inju | ork? □Yas 2□No | | | | |
| S | Attences death | fica | 3 ☐ Suicida 6 ☐ Could not be | 28e. Piece of Injury - At he | oma ferm stre | | | 28f. Location | (Street and Numb | er or Rural Ro | outa Number |
| Š | or A after Dire | ET. | 4 Homicida detarmined | building, atc. (Specif | y) | ot, ractory, office | | City or To | wn, State) | D. D. T. G. G. T. T. G. | ata rvanipor, |
| | To the Hospital or Attendit within 24 hours after death. To the Funeral Director: All completely filled in by the fu | | 29a, Certifiar (Certifying Physi | clan: To the best of my kno | wledge death | nanurad at the t | time data and also | a and due to the | Source(a) and me | | 4 |
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State of Maryland / Department of Health and Mental Hygiene 97

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Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f ahow any Injury or other traumatic event, It a Medical Examine Final be notified a once.

Baltimore, Maryland 21215-0020

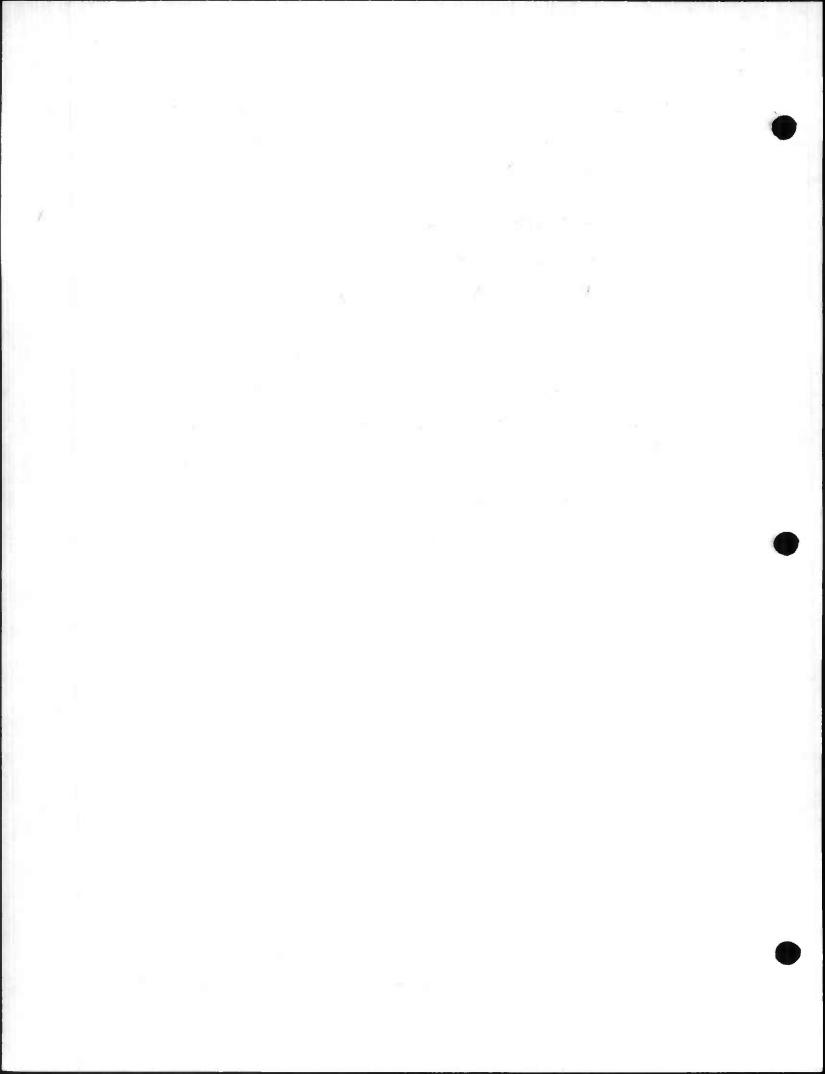
Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit

Division of Vital Records, P.O. Box 68760, reade Sta

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| 0 B | Robert Lee Tyson | | | | Floren | ce Flo | vd | | |
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| | | - + | | | ss of Facility Funeral | | | | |
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State of Maryland / Department of Health and Mental Hygiene Q7 27037

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| | | Sax 7. Age | (In yrs. last | | | ar if Under 24 H | s. 8. Data of Bi | rth a <i>y, Year)</i> | 9. Birthpla Country | ca (Stata or Foreign y) Sylvania |
| ector | 10a. Stata 10b. County Pennsylvania D | | | | Square | | | | | d. insida City Limits 1 ☐ Yas 25€ No |
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| | 21. Signatura of Funeral Sarvice Lice Muchael C 23a. Part I Enter tha disaasa, or cor shock or haart failura. List only | Anoline Hanoline Toplications that caused the rona cause on each line | ha daath. [| 22. Mat Mat P. (| lama and Adritingle Box the moda of a | drass of Fecility EY-Gardine 270, Leo dying, such as cardi | er Funer nardtown ac or raspiratory | al Home, , <u>Maryla</u> | P.A. | 0650 Approximata ntarval Between Onset end Death |
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| mpieted | | | | | | | 24a. Was | an autopsy omad? | evaile | a autopsy findings able prior to pletion of cause ath? |
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| | | 28e. Date of tnjury | 281 | | | | _ | | | |
| Certificati | Accidant invastigation | 28a. Place of injury | y - At homa (Specify) | , farm, streat | | | 28f. Location City or To | (Streat and Numi | ber or Rural F | Routa Number, |
| | 29a. Cartifiar (Check only one) Certifying P. (Check only one) | miner: On the basis of e | xeminetion | ige, deeth or and/or invas | ccurred at the tigation, in m | time, dete and plac y opinion, daath occ | ce, and due to the curred at tha tima, | cause(s) end m data and piece, | annar as stat end dua to th | ed. ha cause(s) |
| _ | 29b. Signature and title of certifier | / | | | 29c. Lice | | | | | |
| | 30. Nama and addrass of person who | completed cause of daa | 1) th (Itam 23 | a) (Type, Pri | nt) | 14285 | | 8-9 | 7-97 | |
| | Medical Certification: To Be Completed by Physician/Medical Examiner To Be Completed | 5. Social Security Number 204-05-7414 Usual Rasidence of Dacedant 10a. Stata 10b. County Pennsylvania 10e. Straat and Number 3421 West Cheste 11. Maritel Stetus 1 Navar Merried 15. Dacedant's E (Specity only highest gr Elemantary/Secondery (0-12) 9th Grade 17. Father's Nama (First, Middla, Las Camillo 19e. Informant's Name/Ralationship Attilia DiBiase 20a. Method of Disposition 12 Burial 2 Cremetion 3 D 4 Donation 5 Othar (Specidal Stranger) 21. Signafura of Funeral Sarvice Lice 19 Saquantially list conditions, if eny, laading to immediate Causa (Finel diseasa or condition rasulting in death) Saquantially list conditions, if eny, laading to immediate Causa (Finel diseasa or condition rasulting in death) Part II. Other significant conditions 23a. Parti Entar tha diseasa, or conshock or heart failura. List only immediate Causa (Finel diseasa or condition rasulting in death) Part II. Other significant conditions 25. Wes casa rafarred to medical available causa. Entar Undarfying Cause (Diseasa or Injury that initiated evants rasulting in death) Part II. Other significant conditions 27. Menper of Death 1 Naturai 1 Naturai 29a. Carifiar 1 Certifying Pr 1 Certifying Pr 1 Certifying Pr 2 Check only 29b. Significant and the of cartifur 29c. Significant and the of cartifur 30. Nama and addrass of person who | 5. Social Security Number 204-05-7414 Usual Rasidence of Dacedant 10a. Stata 10b. County Pennsylvania Delaware 10e. Straat and Number 3421 West Chester Pike ### 11. Maritel Status 11 Navar Merried 2 Marriad 12. Was Decedant 13. Pas 2 2. No. 14. Status 12. Pas 2 2. No. 15. Dacedant's Education 15 | 5. Social Security Number 204-05-7414 Usual Rasidence of Dacedant 100. County 100. City. The Pennsylvania Delaware New 100. Stata 100. County 100. City. The Pennsylvania Delaware New 100. Stata 100. County 100. City. The Pennsylvania Delaware New 100. Stata 100. County 100. City. The Pennsylvania Delaware New 100. Stata 100. County 100. City. The Pennsylvania Delaware New 100. Stata 100. County 100. City. The Pennsylvania Delaware New 100. Stata 100. County 100. City. The Pennsylvania Delaware New 100. City. Stata 100. City. The Pennsylvania Delaware New 100. City. Stata 100. City. The Pennsylvania Delaware New 100. City. Stata 100. City. | 5. Social Security Number 204 - 05-7414 12 M 2 F 7. Age (in yrs. less birthoday) 204-05-7414 12 M 2 F 7. Age (in yrs. less birthoday) 78 Yrs. 12 M 2 F 7. Age (in yrs. less birthoday) 78 Yrs. 12 M 2 F 7. Age (in yrs. less birthoday) 78 Yrs. 12 M 2 F 7. Age (in yrs. less birthoday) 78 Yrs. 12 M 2 F 7. Age (in yrs. less birthoday) 78 Yrs. 12 M 2 F 7. Age (in yrs. less birthoday) 78 Yrs. 12 M 2 F 7. Age (in yrs. less birthoday) 78 Yrs. 12 M 2 F 7. Age (in yrs. less birthoday) 78 Yrs. 12 M 2 F 7. Age (in yrs. less birthoday) 78 Yrs. 12 M 2 F 7. Age (in yrs. less birthoday) 78 Yrs. 12 M 2 F 7. Age (in yrs. less birthoday) 78 Yrs. 12 M 2 F 7. Age (in yrs. less birthoday) 78 Yrs. 12 M 2 F 7. Age (in yrs. less birthoday) 78 Yrs. 12 M 2 F 7. Age (in yrs. less birthoday) 78 Yrs. 12 M 2 F 7. Age (in yrs. less birthoday) 78 Yrs. 12 M 2 F 7. Age (in yrs. less birthoday) 78 Yrs. 12 M 2 F 7. Age (in yrs. less birthoday) 78 Yrs. 12 M 2 F 7. Age (in yrs. less birthoday) 78 Yrs. 12 M 2 M 2 F 7. Age (in yrs. less birthoday) 78 Yrs. 12 M 2 F 7. Age (in yrs. less birthoday) 78 Yrs. 12 M 2 F 7. Age (in yrs. less birthoday) 78 Yrs. 12 M 2 F 7. Age (in yrs. less birthoday) 78 Yrs. 12 M 2 F 7. Age (in yrs. less birthoday) 78 Yrs. 12 M 2 M 2 F 7. Age (in yrs. less birthoday) 78 Yrs. 12 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M 2 | 5. Social Security Number 204-05-7414 Security Number 204-05-7414 Security Number 204-05-7414 Security Number 108. State 10b. County 10b. City, Town or Location 10a. State 10b. County 10b. City, Town or Location Newtown Square 3421 West Chester Pike #A37 10f. Zip Cod 1900. Streat and Number 3421 West Chester Pike #A37 10f. Zip Cod 1900. Streat and Number 3421 West Chester Pike #A37 11. Mariet Stetus 11. Mariet | Social Security Number 2.04 - 0.5 - 7.414 Value Rasidance of Decodent 10k Value Valu | Social Social Social Power More of Discadant 100 pt | S. Social Security Number 204 - 0.5 - 74.14 Usual Residence of Discoeders Tool City, Town or Location Town of Location | Social Security Number |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Defe of Death 3. Time of Death Month Dey **Physician** Gerald Weaver DOUB 1621 August 25, 1997 /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Washington County Hospital Hagerstown Washington 5. Social Security Number ff Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funerai** 8. Date of Birth (Month, Day, Year) Birthplece (Stete or Foreign Country) Days 1⊠M 2□ F Hours 68 Yrs. 220-26-7459 Director January 22,1929 Maryland Usuel Rasidence of Decedent 10a, State 10b. County 10c. City, Town or Location r than "naturel", or itema 23a or 28a-f show the Medical Examiner, must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☒ No Director Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Counfry? 16921 Sterling Road 21795 USA 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☒ No Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Maritel Status 1 ☐ Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: p 3 Widowad 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elamantary/Sacondary (0-12) Collega (1-4or 5+) carpenter construction 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Melden Sumeme) Be 12 should be fi end Mental I is marked of George Daniel Doub Mary Kathryn Weaver 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straet and Number or Rural Route Number, City or Town, Stete, Zip Code) nt of Health e Helen V. Doub - wife 16921 Sterling Rd., Williamsport, Md. 21795 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or Greenlawn Memorial Park 8-29-97 4 ☐ Donation 5 ☐ Othar (Specify) Williamsport, Md. 21. Signatura of Funeral Service Licensaa 22. Name and Address of Fecility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease or complications that caused the death. Do not antar the mode of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List onty ona causa on aach line. Approximate Intarval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical keyo cardo **Examiner** Due to (or as a consequence of) therosoper Sequentially list conditions, if any, leading to Immediate causa. Entar Undertying Cause (Disease or Injury that Initiated events rasulting In death) Last Due to (or es e consequence of) Physician/Medical the Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown lensbar sprie and Records, þ 8 24b. Wera autopsy findings available prior to completion of cause 24a. Was an autopsy performed? Completed of daath? 1 Yes 1 ☐ Yes 2 ☐ No certificate Vital Be 25. Was casa raferred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 of After this To the Hospital or Attending Pt within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Division Injury 1 Natural 5 Pending investigation 1 Yes 2 No 201. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 2 Accident 6 Could not be datermined 3 Suicide 4 Homicide 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basic of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifiar 29b. Signatura and title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year)

30. Name and address of person who complated causa of death (Item 23a) (Type, Print)

32. Pegistrar's Signature Sylvia Davidson

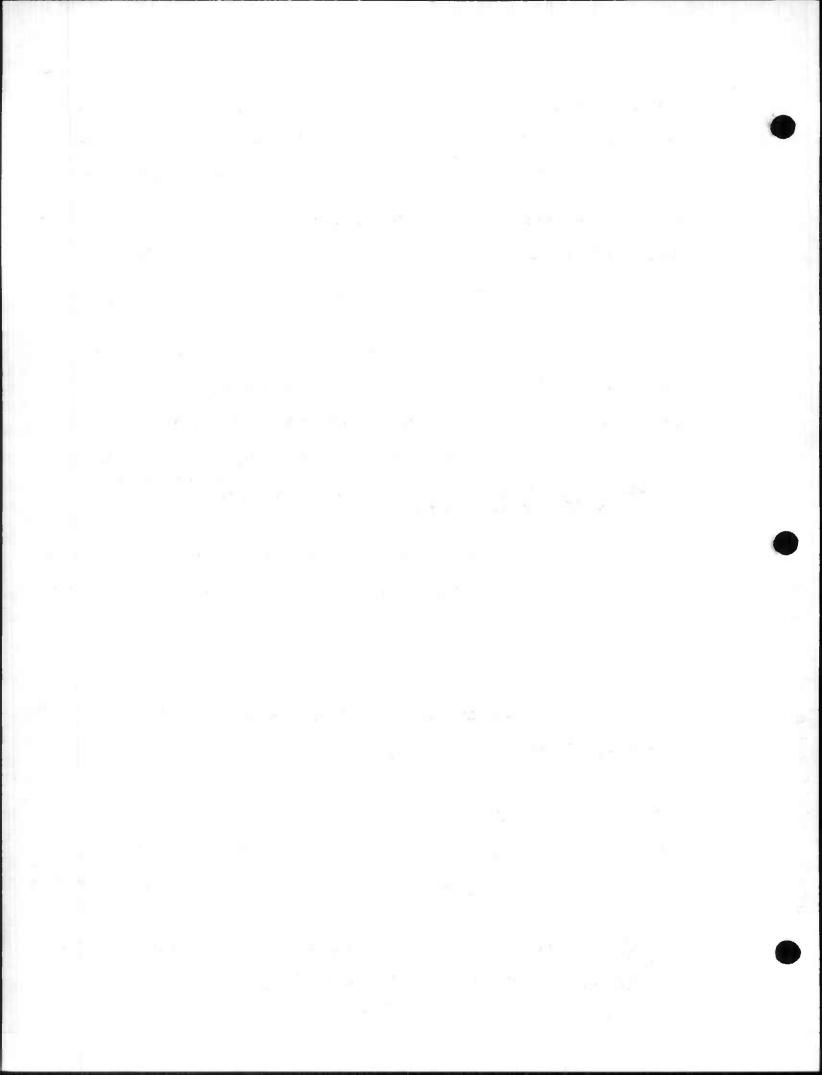
H.N. Wocks

31. Data tiled (Month, Day, Year) AUG 2 0 1997

Registrar

lisave R

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0.7

| Di- | | 1. Decedent's Name (First, Middle, | Lest) | | | | | 2. Date of | | V | 3. Time of Death |
|--|---------------------|---|--|------------------------------------|--------------------------------|--|---|---|---|---------------------------|---|
| Physical /Media | | Walter So | ott DRII | L. Sr. | | | | Month Augu | st 20, 1 | Year 997 | 10:50 A |
| Examir | | 4e. Fecility Name (If not institution, | give street end nur | n <i>ber)</i> | | | 4b. City, Town, | or Location of De | | | 10.50 11 |
| | | Ravenwood Lut | | llage | | | Hager | | | shing | ton |
| Funeral Director | | 217-10-2642 | 3. Sex 1 | 7. Age (In yrs 86 | | y) if Under 1 Ye Months Day | | lin. (Month, | Birth Dey, Yeer) 22 1910 | | olece (State or Foreig otry) yland |
| A III | | Usuat Residence of Decedent 10a. Stete 10b. County | | 10c. C | ity, Town or | Location | | | | 1 | Od. Inside City Limits |
| a or 28a-f show | tor | Maryland Washi | oton | | Насе | erstown | | | | | 1 ☐ Yes 2 🏋 No |
| or 28 | Sirec | 10e. Street end Number | .8.011 | | | 10f. Zip Code | | | 10g. Citizen of | Whet Cour | ntry? |
| rms 23a crewath | ai | 19809 Scott Hill | Drive | | | 217 | 42 | | U.S. | Α. | |
| ntal hygiene. nd other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be notited at | by Funeral Director | 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced | tf Yes, Giv | rces? 2 No | | Wes Decedent of If Yes, spacify C | | (Specify Yes or lerto Rican, etc.) | No- 14. Ra | ca - Americ ck, White, | etc. |
| on E | ed | 15. Decedent's | | etes: W.W. | | edent's Usuat Occ | unation | | 16b. Kind of B | | ite |
| nd Mental Hygiene. marked other than "nat umatic event, the Medica | Completed | (Specify only highest Elementary/Secondary (0-12) | Coilege (1 | -4or 5+) | (Giv | re kind of work doi DO NOT use ret | ne during most of | working | | | ducation |
| other | Be C | 17. Father's Name (First, Middle, La | | | Car | pencer | 18. Mother's N | Name (First, Midd | fle, Meiden Sumer | | ducation |
| Aenta rked tic ev | ToB | George W. Drill | | | | | Mary | A. St. | Clair | | |
| and a | | 19e. Informant's Name/Retationship | (Type, Print) | | 19b. Ma | iling Address (Stre | et end Number or | Rural Route Nun | nber, City or Town | , Stete, Zip | Code) |
| n 27 I | | Judith Kendall - | - Daughte | r | 216 | 33 Kelso | Drive | Hagerst | own, Mary | land | 21742 |
| Department of Health and Menta Important: If Itam 27 Is merked any injury or other traumatic evence. | | 20e. Method of Disposition 1 | | State | cemetery, cr | position (Neme of emetory or other p ill Cemet | | 8/22/97 | 20c. Location | | wn, Stete Maryland |
| Departn Importa any inju | | 21. Signature of Funerei Servica Lic | ensee | | | 22. Name and Add | | | Funeral | | mary rama |
| 2 5 8 | | | | | 4 | 15 E. Wi | lson Blv | d. Hage | erstown, | Md. | 21740 |
| ysician Medical taminer | | 23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Ceuse (Finat disease or condition resulting in deeth) | | E BRONG | CHOPNE | UMONIA | ying, such as care | nec or respiratory | arrest, | i i i | Approximate Interval Between Onset end Death |
| | ner | | CHRO | | or es e cons STRIICT | equence of): IVE PULM | ONARY DI | SFASE | | м | ANY YEARS |
| nd transi | Examiner | Sequentially list conditions. | b | | or as a cons | | ONART DI | DIADE | | I I | ANI ILAKS |
| sian e | | Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or injury | | | | | | | | | |
| physician end s the buriel-transit | edicai | thet initiated events resulting in death) Lest | C | Due to (| or es a conse | equenca of): | | | | | |
| 0 0 | - | | d | | | | | | | | |
| for use | cian | | | | | | | | | | |
| ed by the deteched | Physician/N | Pert II. Other significant conditions | contributing to de | eth but not res | suiting in the | underlying cause | given in Part I. | | | | the cause of death |
| 90 | by P | ALZHEIMERS DISE | ASE, ART | ERIOSC | LEROTI | C HEART | DISEASE, | _ 10 | Yee 2 No | 3 Prob | pably 4 Unknow |
| s been sign should be | Completed b | IMPLANTED CARDI | AC PACEM | AKER, | OBESIT | Y, DIABE | TES | | as en eutopsy rformed? | ave | ere eutopsy findings bitebie prior to mpletion of cause deeth? |
| page 2 | E O | MELLITUS-TYPE I | T. CONTR. | ACTURES | S OF E | XTREMITT | ES | 10 | Yes 20 No | | Yes 2 No |
| certificate rector, pa | Bec | 25. Wes case referred to medical | 1, 001,110 | 1010112 | | | | Deeth (Check only | | | 100 2010 |
| Ø 10 | To | examiner? 1 ☐ Yes 2 ☑ No | Hospital: 1 tn | patient 2 | ER/Outpation | ent 3 DOA | Whor | | | er (Specify | () |
| death. ctor: After th y the funeral | | 27. Manner of Deeth 1 Maturat 5 ☐ Pending 2 ☐ Accident Investigati | | f Injury n, <i>Dey Year)</i> | 28b. Time Injury | W | | lursing Home 5 ☐ Residenca 8 ☐ Other (Specify) 28d. Describe how Injury occurred] No | | | |
| al Director: | Certification: | 3 Suicide 6 Could not determine | d 200. Place | of Injury - At h g, etc. (Speci | a | 28f. Location City or 7 | (Street and Numb own, Stete) | er or Rura | l Route Number, | | |
| within 24 hours and To the Funeral Dir completely filled in | edical | 29e. Certifier 1 ☐ Certifying F (Check only one) 1 ☐ Medical Exp | hysician: To the bandiner: On the band menni | sis of examina | owledge, dee ation end/or i | th occurred at the nvestigetton, in my | time, date and ple optnion, deeth oc | ca, and due to the curred et the time | e cause(s) end ma e, dete end pieca, | anner es st end due to | eted. the ceuse(s) |
| To the | - | 29b. Signeture end title of certifier | /, | / | | 29c. Lice | nse number | | 29d. Date signe | d (Month, L | Day, Year) |
| 11 | | 30. Name end address of person who | of fr | of death (III | n 02c) (T | | 07857 | | August | 21, 1 | .997 |
| | - 1 | Dr. Edson B. M | | | | | | | | | |

DHMH 16 Rev 6/95

Programme and the state of the made which the state of

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day **Physician** Month August 27, 1997 Ennis 8:10 a.m. /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Edw.W.McCready Memorial Hospital Crisfield Somerset ff Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1□M 20XF 218-05-8318 90 Yrs. Director Aug. 28, 1906 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health end Mental Hygiene. nt: If Item 27 is marked other than "natural", or items 23s or 28s-1 ahow 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Crisfield 1 ☐ Yas 2 XNo Maryland Somerset Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26532 Mariners Road 21817 USA by Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Giva Year or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grada complated) al Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Office Manager Nursing Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Wilson Lucy Lawson 2 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health et Important: If Item 27 is any Injury or other traughtes. Peggy Jane Tull (daughter) 26532 Mariners Road - Crisfield, MD 21817 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burlat 2 ☐ Cramation 3 ☐ Removal from State Sunnyridge Memorial Park 8/30/97 4 ☐ Donation 5 ☐ Other (Specify) Crisfield, MD 21. Signature of Funeral Sarvice Licensee 22. Nama and Address of Facility
Bradshaw & Sons Funeral Home Karlue H. Shert (lemin) 306 W. Main St. - Crisfield, MD 21817 Robert H. Bradshaw 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final MEU MONIA disaase or condition resulting in death) Examiner Due to (or as e consequence of) Examiner DISEASE CORONARY ARTERY The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or es a consequence of) Box 68760. the attending physician thed for use as the buna Physician/Medical Dua to (or as a consequence of) Pert tl. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by t 1 Yes 2 XNo 3 Probably 4 Unknown þ Completed 24b. Were sutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? peen has 1 ☐ Yes 2 ☐ No certificate or Attanding Physician: Be 25. Was cese referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 2√ No Other: 4 Nursing Home 5 Realdence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. tnjury at Work? 28d. Describe how injury occurred Certification: 28b. Time of After 5 Pending Natural 2 Accident 1 ☐ Yes 2 ☐ No death. investigation after death filled in by the 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homleide within 24 hours a To the Funeral C completely filled Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as stated.

2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cauae(s) and manner stated. 29a. Certifier Medical (Check only one) eun 29b. Signature and title of certifier 29c. Licansa numbar 29d. Date signed (Month, Day, Year) D 48098 AUC. 27, 1997 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) Vijay Karumbunathan, M.D. - 201 Hall Highway - Crisfield, MD 21817

State Registra

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Julia Davidson Randall

DHMH 16 Ray 6/95

and the second s

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | | | State of M | aryland | | tificate o | nealth and l f Death | • | gierie Reg. No. | 37 | 27041 |
|--------------------------------|---|----------------|---|---|------------------------------|--------------------------------|--------------------------------------|---|--|------------------------------------|-----------------------------|--|
| | De. | | 1. Decedant's Nama (First, Middla, L | ast) | | | | | 2. Data of De | ath | | 3. Tima of Death |
| | Physic /Medi | | GEORGE | Ρ. | FOUNT | AIN | | | AUG | Day | 1997 | 0130 |
| | Exami | | 4a. Facility Nama (If not institution, g | iva street and number) | | | | 4b. City, Town, or | | | | |
| | | | ATLANTIC GENERA | L HOSPITAL | | | | BERLIN | | WOR | RCESTI | ER |
| | Funeral Director | | 222-14-0585 | Sax 7. Ag 1 AM 2□ F | _ | ast birthday) 1 Yrs. | If Undar 1 Yau Months Day | | (Month, Da | th ly, Year) 2, 1926 | 9. Birthpi Count DELA | aca (Stata or Foraign MARE |
| | and | | Usual Rasidance of Decedant 10a. Stata 10b. County | | 10c. City, | , Town or Loc | ation | | | | 10 | Od. Inside City Limits |
| | with the Marylans a or 28a-f show be notthed at | tor | DELAWARE SUSSEX | | FP | ANKFOR | חי | | | | | 1 ☐ Yas 2 No |
| | 1 the | Director | 10e. Street and Number | | TI | MINITON | 10f. Zip Code | | | 10g. Citizen of V | What Coun | try? |
| | N With | | RT. 2 BOX 96 | | | | 19 | 9945 | | USA | | |
| | Hema 2 | Funeral | 11. Maritai Status | 12. Was Decedant | Evar in U,S | 3. 13. W | | f Hispanic Orlgin? (Suban, Maxican, Puart | pecify Yas or No | | e - Amarica | |
| Baltimore, Maryland 21215-0020 | 8 8 | by | 1 ☐ Navar Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | Armed Forces? 1 Yas 2 If Yas, Giva Yaar or Datas: | No | | Yas, specify Co | | o Hican, atc.) | Specify | ck, Whita, a | HITE |
| 2-0 | 72 hours "natural", | ted | 15. Decedant's E (Specify only highast g | | | 16a. Deceda | ant's Usual Occ | supation | rkina | 16b. Kind of Bu | usinass/Ind | ustry |
| 2 | within ene. | Be Completed | Elemantary/Secondary (0-12) | Collega (1-4or | 5+) | | | na during most of wor ired) | Kiriy | | | |
| 2 | filed within Hygiene. other than sent, the Henry | Cor | 9 | *1 | | M | IECHANI (| | | MARIN | | |
| anc | S ta b | | 17. Fathar's Nama (First, Middla, Las | , | | | | | na (First, Middla, | | 18.) | |
| 2 | is 1 and 2 should be file and Mental them 27 is marked or other traumatic even | To | GEORGE FOUNTA | | | 10h Mallins | Address /Ctre | ELIZAE | | INANT | Conta Tin | Codel |
| Ma | d2s th an 17 ls r | | ELEANOR A. FOUNT | | | | | FRANKFOR | | | | Coda) |
| e, | Health Health tem 27 | | 20a. Mathod of Disposition | MIN, WILL | 20b. Pla | ace of Dispos | Ition (Nama of | | Data | 20c. Location - | | wn, Stata |
| 9 | Pages ent of rt: If It | | 1 ☐ Burial 2 【XCramation 3 ☐ 4 ☐ Donation 5 ☐ Othar (Spec | | | | atory or other p | | 8/23/97 | SALISBU | RY. M | ARYLAND |
| alti. | permit. Pages Department of Important: If it any Injury or o | | 21. Signature of Tunaral Sarvica Lice | | JAL. | | Nama and Add | | 3/23/3/ | DIEDIDO | , | IIII BIIII |
| Ö | Den e de | | 1/1/01/ |)V 1 | | HAS | TINGS I | FUNERAL HO | ME. SEL | BYVILLE. | DEL | AWARE 19975 |
| | - | | 23a. Rarti. Entar tha disaasa, or cor shock, or haart fallura. List on | npilcations hat causa | d tha daath. | 1 | | | | | | Approximata |
| | Physician | - 0 | snock, or haart failura. List one | y ona cause on aach ii | na. | | | | | | i | Intarval Between Onsat and Death |
| | /Medical | | Immediata Causa (Final disaasa or condition | a myoc | 200 | 12/ | 10.21 | erction | J | | | 36 hours |
| я | Examiner | | resulting in daath) | a | Dua to (or | as a consaqu | ianca of): | 2,0,, | | | 1 | |
| | P # | Iner | | , h | | | | | | | | |
| | ficate be executed physician and is the burial-transit | Examiner | Sequentially list conditions, | J | Dua to (or | as a consequ | ance of): | | | | | |
| 68760, | be ea ician burla | a E | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury | c | | | | | | | | - 1 N |
| 387 | ate chart | edicai | that initiated evants rasulting in daath) Last | | Dua to (or | as a consequ | ance of): | | | | i | |
| | Seath certific attending p | | | d | | | | | | | | |
| Box | death certif e attending id for use a | clar | Death Other death | | | | | 7-20-10-1-10-1-10-1-10-1-10-1-10-1-10-1- | | | | |
| P.O. | 0 0 2 | Physician/M | Part II. Other signiffcant conditions | contributing to death b | ut not rasur | ting in tha und | dariying causa | givan in Part I. | | Yes 2 No | | the cause of death? |
| | s that | by P | | | | | | | 12 | 2010 | 0_1100 | ably 40 olikiowii |
| Division of Vital Records, | been should | Completed b | | | | | | | 24a. Was perfo | an autopsy ormed? | ava | re autopsy findings nilabla prior to npletion of cause death? |
| Re | 0 - 0 | шо | | | | | | | 10 | Yas 2 1 No | | Yas 2 No |
| ita | ilcian: The certificate rector, pag | BeC | 25. Was casa rafarred to medical | | | | | 26. Placa of Dec | ath (Check only o | | | |
| > | ysician: is certific director, | To B | axaminar? 1 ☐ Yas 2 ☑ No | Hospital: | ant 2 E | R/Outpatient | 3 DOA | Date: | loma 5□ Rasio | | ar (Specify | •) |
| 0 | Attending Physician: or death. sctor: After this certific by the funeral director, | | 27. Mannar of Death 1 ☐ Natural 5 ☐ Panding | 28a. Data of Inju (Month, Da | ry Year) | 28b. Tima of Injury | 28c. In | | | how Injury occur | | |
| io | death. ctor: Af y the fu | atic | 2 Accidant Invastigation | on | ,, | ,, | | ☐ Yas 2 ☐ No | | | | |
| N N | r Atter de irecto | Certification: | 3 ☐ Suicida 6 ☐ Could not datarmine | 28a. Place of Inj | ury - At hon c. (Specify) | na, farm, stra | at, factory, offic | a | 28f. Location (City or Tox | Street and Numb vn, Stata) | er or Rura | Routa Number, |
| | tal o | | | | | | | | | | | |
| | To the Hospital or Attent within 24 hours after deat To the Funeral Director: completely filled in by the | edicai | 29a. Cartifiar 1 ☐ Certifying P (Check only one) | hysician: To the bast minar: On the basis o and mannar st | f axamination | ledge, daath on and/or inva | occurred at tha astigation, in my | tima, data and place y opinion, daath occu | , and dua to tha irred at tha tima, | causa(s) and ma data and place, | annar as st and dua to | ated. tha cause(s) |
| | To the Com | Ž | 29b. Signatura and titia of cartifiar | SIL | - | ./ | | nse number | | 29d. Data signe | d (Month, L | Jay, Year) |
| | | | Robert | Delkis | / | physiu | ~ H | 44283 | | 8/21 | 197 | |
| | 10 | | 30. Nama and addrass of person who Robert Durk | complated causa of c | leath (Itam : | | Print) | | | | | |
| | Y | | 9733 Heeli | Thurs Dr. | rue | | rle, | ms | 218/1 | | | |
| | Sta Registr | | 31. Data filad (Month, Day, Yaar) AUG 2 2 1997 | 32. Registr | ar's Signatu | dall | | | | | | |

State of Maryland / Department of Health and Mental Hygiene 97 27042

| | | | | | (| Cert | tificate of | Death | | | Reg. No. | | |
|---|--|----------------|---|--|--------------|---------|---|------------------------------|------------------------|---------------------------------|------------------------|--------------------------------|--|
| П | 8. | | 1. Decadant's Nama (First, Middle, Last) | | | | | | | 2. Data of De | | W | 3. Tima of Death |
| ĕ. | Physici /Medi | | Daniel John F | itzgerald | | | | | | Month AUG. | 20. | Yaar L997 | 12:07 p.m. |
| | Examir | | 4a. Facility Nama (If not Institution, give | | | | | 4b. City, To | wn, or Lo | cation of Deal | | ounty of Death | |
| П | LAGIIII | iei | | | | | | | | | | 1000 | |
| - | | | 2181 Chesapeake H 5. Social Sacurity Number 6. Sax | arbour Drive | Last high | day | If Undar 1 Yaar | Annar | olis 24 Hrs. | 8. Data of Bi | eth | NNE AR | UNDEL placa (State or Foreign |
| h | Funeral Director | | | M 2□F 42 | | rs. | Months Days | Hours | Min. | May 7, | ay, Year) | Cou | intry) |
| | | | Usuel Rasidanca of Decadant | 42 | | | | | | ray /, | 1933 | Haly | land |
| | tand tand | | 10a. Stata 10b. County | 10c. C | ity, Town | or Loca | ation | | | | | | 10d. Insida City Limits |
| | Many | 0 | Marriand Anna Anna | .d.a1 A | 1 | | | | | | | | 1 ■ Yas 2 □ No |
| | the 28s | Director | Maryland Anne Arun 10e. Street and Number | ide1 All | napo | 115 | 10f. Zip Coda | | | | 10a Citiza | n of What Cou | Poster |
| | With Will | | | Lubarra Darias | E | | 21403 | | | | | | |
| | 2 should be filed within 72 hours efter death with the Maryland end Mental Hygiene. is marked other than "natural", or items 23s or 28s-f show aurmatic event, if a Medical Examiner trans to profitted at | Funeral | 2181 Chesapeake H | | - | | | | | | | d State | |
| | er de | 5 | | 12. Was Decedant Evar in Armed Forcas? | U,S. | 13. W | as Decedant of F Yas, specify Cub | fispanic Orig an, Maxican | gln? (Spe i, Puarto | ecify Yas or No Rican, atc.) | 0- 14 | . Race - Amari Black, Whita | |
| 20 | S of | by F | 1 Nevar Married 2 Married | 1 ☐ Yas 2 ■ No If Yes, Giva | | 1[| ☐ Yas 2 No | Specify: | | | S | pecify: TIL | |
| 21215-0020 | nour nour | D D | 3 ☐ Widowed 4 ■ Divorcad | Yaar or Datas: | | | | | | | | Whi | rce |
| 5 | 72 nat | Completed | 15. Decedent's Edu (Specify only highest grade | | (| Give ki | int's Usuai Occup ind of work done | during most | t of worki | ing | 16b. Kind | of Business/Ir | ndustry |
| 2 | hen vithic | 윤 | Elamantary/Secondary (0-12) | Collega (1-4or 5+) | | | O NOT use retire | • | | | | | - |
| | hygie her t | ပ္ပ | | 2 | HOE | eı | Executiv | | | | - | | Industry |
| ü | tal H od | Be | 17. Fathar's Name (First, Middle, Last) | | | | | 18. Motha | r's Nama | (First, Middle | e, Maiden Si | umeme) | |
| X | should be nd Mental marked o | 2 | William John Fitz | gerald | | | | Alma | Crave | en Davy | | | |
| Maryland | 2 sh end la m | | 19a. Intermant's Name/Relationship (Ty | | 19b. I | Mailing | Addrass (Street | and Numbe | or Rure | A Route Numb | ber, City or | Town, State, Zi | p Code) |
| | DELP | 14 | William Fitzgerald, Jr | ., Brother | P. | 0. | Box 288 | . Mech | nanio | sville | . Mar | vland 2 | 20659 |
| e e | of He for the country of the country | | 20a. Mathod of Disposition | | Place of D | Disposi | ition (Name of atory or other pla | | 1 | Data | | ition - City or T | |
| more, | Page ent c nt: if y or | | 1 ■ Burial 2 □ Cramation 3 □ R 4 □ Donetion 5 □ Other (Specify) | amoval from Stata | - | _ | ace Cemete | | 8- | 23-1997 | Helen. | Marylar | nd |
| a | artm ortar inju | | 21. Signature of Cheral Savige Cic | 8-1/1 | | | | - | V = . | c | | | |
| Ö | permit. Pages 1 en Department of Hee Important: if Item 2 any injury or other once. | | Coller | Thomas a | | | Nama and Addra | | | | | | |
| | | | Edward N. Brinsfie | | th Dane | - | 55 Hollyw | | | | - | yland 20 | |
| | | | 23a. Part1. Entar tha diseasa, or compli shock, or haart feilura. List only or | e ceuse on aach lina. | ith. Do no | t entar | r tha moda or dyli | ng, such as | cardiac c | or raspiratory a | arrest, | 1 | Approximata Intarval Between Onsat and Death |
| 4 | Physician /Medical | | Immadiate Ceuse (Finel | 1.\ | | | | | | | | 1 | Orisat and Death |
| | Examiner | | disaasa or condition rasulting in daath) | Han | gin | 5- | | | | | | | |
| | | - | , | Due te | of as e co | nequi | ence ot): | | | | | | |
| | ted nsit | Examiner | _ b | | | | | | | | | | |
| | setificate be executed ding physicien and se es the burial-transit | хаг | Sequantially list conditions, if any, laading to immediate | Due to | or as a co | nsequ | ance ot): | | | | | | |
| 68760, | be e icien buria | | Cause (Disease or injury | | | | | | | | | | |
| 8 | phys the | edical | that Initiated evants rasulting In death) Last | Dua to | or as a co | nsequa | anca of): | | | | | | |
| × | ding | /Me | | | | | | | | | | | |
| 80 | | | | | | | | | | | | | |
| o. | 0 0 0 | Physician | Part II. Other significant conditions con | tributing to death but not re | sulting In t | ha und | darlying causa giv | an in Part I. | | 23b. Did | tobacco u | e contribute t | o the cause of death? |
| <u>.</u> | d by | Phy | | | | | | | | 10 | Yes 2,00 | No 3□Pro | bably 4 Unknown |
| Ś | lew requires thet the es been signed by the 2 should be detache | by | | | | | | | | | | | |
| Records, | v require been si should I | ted | | | | | | | | 24a. Was | s an autopsy ormed? | | ara autopsy tindings vailable prior to |
| Ö | as be | ple | - | | | _ | | | | | | C | omplation of causa death? |
| | 0 - 8 | Completed | | | | | | | | 1,50 | Yas 2□ | No 1/ | QYas 2□ No |
| Vita | certificate irector, pag | d) | 25. Was casa referred to medical | | | | | 26 Place | of Death | (Check only | | | |
| | Physicien: r this certific rral director, | 0 8 | axaminer? XXXas 2□ No | ospital: | FR/Outo | atlant | 3□ DOA Oth | ar. | | | | Othar (Speci | 60 |
| 0 | Phys erthis eral di | n: T | 27. Mannar ot Death | 28a. Deta of Injury | 28b. Tir | na of | 28c. injur Wor | | | 28d. Dascribe | how injury | occurred | |
| Division of | Attending Isr death. | Certification: | 1 ☐ Natural 5 ☐ Pending invastigation | F (Month, Day Year) | For | nux. | | rk? Yas 2√Zit | No - | subject | thang | fact self | } |
| <u> </u> | Attendion of the function of t | fice | 3 Suicida 6 ☐ Could not be | 28a, Place of Injury - At | noma, fam | Jul. | | | | 28f Location | (Street and | Number or Rur | al Boute Number |
| É | 7570 | ert | 4 Homicida | building, atc. (Spec | Her Her | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | City or To | wn, Stata) | 2181 Chera | perde tribar |
| | ppita ours serai | | 29a. Cartifier 1□ Certifying Phys | ician: To tha best of my kn | | | occurred at the tir | na data and | d place | manage | CO MI | nd mannar as a | stated |
| | To the Hospital c within 24 hours all To the Funeral c completely filled i | edical | (Check only one) 2 Medical Examin | er: On the basis of exeminand mannar stated. | ation and/ | or inva | stigation, In my o | pinlon, daat | th occurre | ed at tha tima, | data and p | lace, and dua I | o tha causa(s) |
| | ithin o the | ₹ | 29b. Signature and title of certifier | | | | 29c. Licans | a number | | | 29d. Data | signed (Month, | Dav. Year) |
| | ⊢ \$ F ŏ | | · / 1/1 | 11 | | | | C.M.E | | | | | |
| | | | Menny / G | rute, no | | | | - 171 - E | | | AUG | , 21, 1 | .99 / |
| 10 | 2 | | 30. Name end eddrass of person who con | | m 23e) (T | ype, Pr | Street, | Ral+ | imor | me Mar | Free ly | 21201 | |
| 1 | | | Dinnis J. Chu 31. Data tiled (Month, Day, Year) | 10,10 | | _ | | Durt | . AILOI | C, FIGIL | Утапи | 21201 | |
| | Sta Registr | | AUG 22 1997 | 32. Ragistrar's Sign | u-Road | all | | | | | | | |
| | riegisti | 211 | 100 nn 1931 | your amount | | 4 | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene

27043 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month Mary Ellen Frank 18, August 1997 0030 /Medicai 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Kent & Queen Annes Hospital Chestertown Kent 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthday) **Funeral** 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) Days Hours 1 ☐ M 2X F Director 220-16-9486 January 11, 1921 Maryland the Maryland 10a State Show 10h County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f shadical Examiner must be notified Maryland Director Kent Chestertown 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 104 Iris Road 21620 Funeral U.S.A. 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ON if Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 3 No Specify: Completed by Specify: White ₩idowed 4 Divorced the Medical 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) Homemaker Domestic/Own Home permit. Pages 1 and 2 should be filed Department of Health end Mental Hygid Important: If item 27 is marked other i any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Raymond Watson Mary Virginia Elburn Carolina North 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Beverly Stroupe/Daughter 6308 New Sharon Church Road, Roguemont, 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State Mary Land 20e. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata Church Hill Cemetery/August 20, 1997 Church Hill, 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620

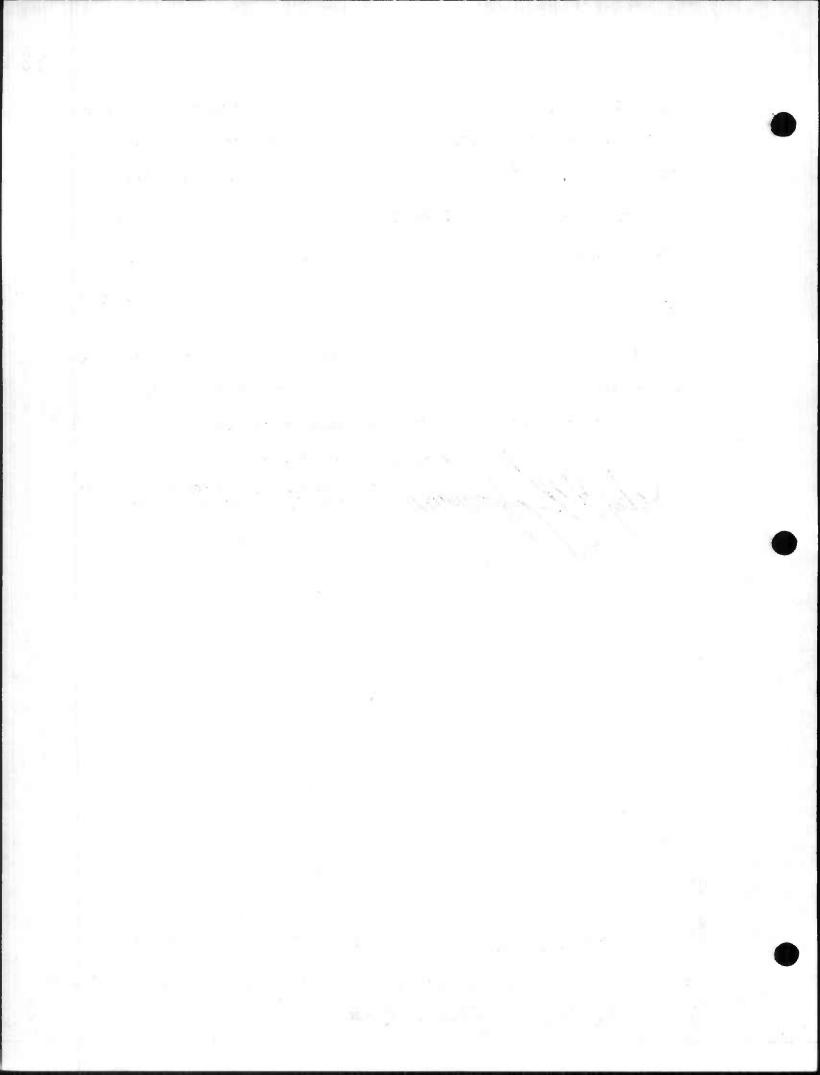
Approximately the mode of dying, such as cardiac or respiratory arrest,

Approximately the mode of dying. Approximate interval Between Onset end Death **Physician** Condio Respiratory Arrest. /Medical immediate Cause (Final 30 min disease or condition resulting in death) **Examiner** Physician/Medical Examiner Advanced Gostro Tutestinal Tract Malignous The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting In death) Lest Due to (or as a consequence of): for use as the bunal-trar P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, þ 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was en autopsy performed? After this certificate has 2□No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical 28. Place of Death (Check only one) Hospitel: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 27. Manner of Deeth 28c. Injury at Work? Certification: 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Neturai death. 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 ☐ Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) end menner as stated.

| Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) end menner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D0050996 8 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Street Chestertown MD 21620 Stoddard mD 100 Brown 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Julia Davidson-Randell AUG 20 Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 97

97 27044

| | | | | | | Cert | tificat | e of | Death | | Re | eg. No. | | | |
|---------------------|---|----------------|---|---|----------------------------|-------------------|------------------------|-----------------------|---|------------|-----------------------------------|----------------------------|---------------------------------------|--|----------------|
| | 2 1 | | 1. Decedant's Name (First, Middle, Las | st) | | | | | | 2. | Date of Deat | h | Vana | 3. Tim | f Deeth |
| | Physic /Medi | | DAVID ALLER | N GUY | SR_ | | | | | I | August | 22 19 | 997 | 2:25 | AM. |
| 1 | Exami | | 4a. Facility Nama (If not institution, give | a straet and number) | -DR | | | | 4b. City, Town | , or Local | tion of Death | 4c. Count | y of Death | | |
| 1 | | | 40488 Cutter Lan | e | | | | | Leonard | ltowr | 1 | St. | Mary | | |
| | Funerai Director | | 215-36-3796 | ex 7. Age | (In yrs. last b | Vrs. | If Under Months | 1 Year Days | if Under 24 Hours | Min. | Date of Birth (Month, Day, an 20, | Year) 1937 | Cou | place (State ntry) yland | or Foraign |
| | Maryland -f ehow | tor | Usual Residence of Decedant 10a. State 10b. County | | 10c. City, To | wn or Loca | | Lan | | | | | | 10d. Inside t | City Limits |
| | 28s | Director | MD St. M 10e. Street and Number | ary | 4040 | o Gui | 10f. Zip | | . ಆ | | 10 | 0g. Citizen of | What Cou | ntrv? | |
| | a 23a or | | 40488 Cutter Lan | T . | | | | 206 | | | | USA | | | |
| Maryland 21215-0020 | d within 72 hours after death with the Maryland giene. I'r than "natural", or ferna 23a or 28a-f show The Medical Examiner must be notified at | by Funeral | 11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced | 12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: | | 11 | Yes, spec | cify Cub | dispanic Origin an, Mexican, F Specify: | uerto Ric | y Yes or No- | Bla | ce - Americ nck, White, fy: Whi | etc. | |
| 5-(| 72 h | Completed | 15. Decedant'a Ed (Specify only highest gra | ucation da com <i>pleted</i>) | 18 | a. Decede | ind of wo | rk done | during most of | f working | | 16b. Kind of B | Business/In | dustry | |
| 121 | ithin | Jdu | Elementary/Secondary (0-12) | Collaga (1-4or 5+ | H) | life. Do | O NOT us | se retire | d) | | | | | | |
| 7 | | | 12 | | В | arbei | r | | T | | | Own Bu | | SS | |
| and | S E O S | Be | 17. Fathar's Name (First, Middle, Last) | _ | | | | | | | irst, Middle, N | | - | | |
| 7 | 2 should be to and Mental I is marked of reumatic ever | To | William Alphon | - | | | | | Lilli. | | Alice | | ham | | |
| Mai | | | 19a. Informant's Name/Ralationship (7 | | | | | | Lane, | | | | | Code) | |
| | 1 and 2 Health em 27 i | | Clarice J. Guy/ | Wife | 20b. Place | | | | Lane, | | -1- | | | | |
| Baltimore, | permit. Pages 1 and 2 Department of Health Important: If item 27 is any injury or other tre | | 20a. Method of Disposition 18☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify | | com nt | ORI OFOR | stone or o | thar ala | ∞) Garden | | | 20c. Location Leonard | | | |
| Ball | Depart Import any inj | | 21. Signatora of Funeral Service Licen | see A | . 01) | Ma: | Name an | d Addra | ss of Facility. Gardi | ner l | Funera | | P.A | • | |
| | | | 23a. Part1. Enter the disease, or domp | plications that caused to | the death. Do | | | | | | | | 1 | Approxima Interval Be | ate obvious |
| | Physician /Medical Examiner | | Immadiata Causa (Final disaase or condition resulting in death) | . Ren | | C | 211 | | Car | Cina | oma | | 1 | Onsat and | nouth |
| | | ē | | С | Dua to (or as a | consequ | ence of): | | | | | | | | |
| , | eath certificate be executed attending physician and for use as the buriel-transit | Examiner | Saquentially list conditions, if any, leading to immadiata | b | Due to (or as a | a conseque | enca of): | | | | | | | | |
| 68760, | cate be ophysicial the buri | edlcai I | cause. Enter Undarlying Cause (Diseasa or Injury that initiated evants resulting in death) Last | c | oue to (or as a | conseque | ence of): | | | | | | | | |
| × | certifi ding l | Σ | | d | | | | | | | | | į | | |
| Box | death de atten | Slan | | | | | | | | | | | 1 | | |
| P.O. | the d | Physician/ | Part II. Other significant conditions co | intributing to death but | not resulting | in tha und | derlying c | ause gi | en in Part I. | | | bacco use co | 1 | | |
| | ires that the signed by d be detact | by Ph | | | | | | | | | 1 □ Ye | 2 No | 3 Pro | bably 4 |] Unknown |
| Records, | regu | Completed | | | | | | | | | 24a. Was ar perform | | av | era autopsy ailable prior empletion of death? | to |
| œ | The law ata has b paga 2 s | E O | | | | | | | | | 1 □ Y e | s 2 No | 1[| Yes 2 | □ No |
| Vita | ician: The certificata rector, pag | Be | 25. Was case referred to medical examiner? | | | | | | 26. Placa of | Death (C | Check only on | a) | | | |
| of v | Physician: this certific ral director, | 2 | 1 Yes 2 No | Hospital: 1 ☐ Inpatian | t 2 ER/C | Outpatient | 3□ DC | Ott | ner: 4 🗆 Nursi | ng Home | 5 Reside | nca 8 🗆 Oti | her (Specia | (y) | |
| ono | Attending PI or death. ector: After the by the funera | | 27. Manner of Death 1 Statural 5 Pending 2 Accident Investigation | 28a. Date of Injury (Month, Day | Year) 28b. | Time of Injury | м 2 | 8c. Inju Wo 1 [| yat rk? Yes 2 ☐ No | | f. Describe ho | w injury occu | rred | | |
| Division | 크중불로 | Certification: | 3 Sulcide 6 Could not be determined | 28a. Place of Injur building, etc. | ry - At homa, (Spacify) | farm, stree | et, factory | r, office | | 281 | Location (St. City or Town | reet and Num o, State) | ber or Run | al Route Nu | m <i>ber</i> , |
| | To the Mospital or within 24 hours after To the Funerel Diff complately filled in | edical | 29a. Certifier 1 CertifyIng Phy (Check only one) 2 Madical Exam | ysician: To the best of iner: On the basis of e | examination a | a, death o | occurred stigation, | at tha ti | ma, data and p ppinion, death | occurred | due to tha ca at the time, da | use(s) and mata and place, | anner as a | tated. | (s) |
| | o the o the omple | Me | 29b. Signature and titla of certifier | andmannar state | - | | 290 | . Licans | a number | | 29 | 9d. Data signe | ed (Month. | Day, Year) | |
| | F 3 F 8 | | M. GV MO. D 40780 | | | | | | | | | 80 08, 22,97 | | | |
| | | | 30. Nama and address of person who de Hassan Ghazal | | ath (Itam 23a) |) (Type, Pr | | nami | town, N | VID 3 | 20650 | | | | |
| ľ | Sta | | 31. Date filed (Month, Pay, Year) AUG 26 19 | 97 32 Aegistra | 's Signatura | Cardall | | المحمد | COWITY I | ے س | .0000 | | | | |

97-4734-037 CIP Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97

ne 97 2704

| CIP | | |
|--------------|--------|---------|
| JAMES | CICERO | GRIFFIN |

Certificate of Death

og. No.

29d. Date signed (Month, Day, Year)

AUGUST 22, 1997

| | Physic /Medi | | Decedent's Name (First, Midd James Cicero | | | | | | | 2. Date of Do Month AUGUST | Day | Year 997 | 3. Time of Deeth 1:20AM |
|--------------|---|--------------------|---|--|--|---|---|-----------------------|--|---|----------------------------|--------------------------------------|--|
| | Exami | | 4a. Facility Name (If not institution | n, give street and n | um <i>bar)</i> | | | | 4b. City, Town, or | | h 4c. Cour | nty of Death | |
| t | Funeral Director | | IN FRONT OF 218 5. Social Sacurity Number 241–44–4781 | 885 NEWTO 6. Sex 1 ■ M 2□ F | WNE NEC | | 1 44 | 1 Year Days | LEONAF If Under 24 Hr. Hours Mir | s. 8. Date of Bi | rth ay, Year) | Cou | 'S place (State or Foreign ntry) Carolina |
| | Maryland H show | tor | Usual Residence of Decedant 10a. State 10b. County Maryland St. I | Mary's | | ity, Town or L | | | | | | | 10d. Inside City Limits |
| | th with tha 23a or 28e | al Director | 10e. Street and Number 21885 Newtowne | Neck Roa | d | | 10f. Zip | Code 2065 | 0 | | 10g. Citizen o | | |
| 020 | s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Exerciper must be notified at | by Funeral | 11. Marital Status 1 □ Navar Married 2 □ Mar 3 □ Widowed 4 ■ Divorced | ried Armed F | 2 🗆 No | | Was Daced If Yes, speci 1 Yes 2 | ify Cub | Hispanic Origin? (an, Mexican, Pue Specify: | Specify Yas or Norto Rican, atc.) | | ace - Amari lack, White, hify: | |
| 21215-0020 | e filed within 72 ho al Hygiena. I other than "natur vent, the Medical | Completed | 15. Deceder (Specify only highe Elementary/Secondary (0-12) | | (1-4or 5+) | (Giv life. | edent's Usual e kind of work DO NOT use | k done e retire | during most of we | orking | 16b. Kind of | Business/Ir | |
| Maryland | 2 should be filed and Mental Hygis Is marked other raumatic event, the | To Be C | 17. Fether's Name (First, Middle, Thomas Edward | | | | | | | eme (First, Middle Clyde St | , Maiden Sume | | |
| | is 1 and 2 shoot Health and Item 27 Is m | | 19a. Informant's Name/Relations Jeffrey J. Griffin | 3220 | 004 | Law | Sandgat | es R | and Number or Fload, Mecha | nicsville | Marylan | d 206 | 59 |
| altimore, | permit. Pagas Department of Finportant: if its any injury or of once. | | 20a. Method of Disposition 1 ■ Buriai 2 □ Cremation 4 □ Donation 5 □ Other (S | | State | cemetery, cre | eterans | her pla | metery | Date 8-27-1997 | | am, Ma | ryland |
| Bal | Departi Depart Impor any In | | 21. Signatu Funeral Britis | Suy, L | , M00052 | 2 | 2955 Ho | llyw | ess of Facility Bri cood Road, | Leonardtov | yn, Maryl | me, P. | A. 650-0279 |
| | Physician /Medical Examiner | - | 23a. Part1. Enter tha disaase, or shock, or heart failura. List Immediate Cause (Final disease or condition resulting in death) | only one causa on | OKE S | | CAM | | ng, such as cardia | | | ws | Approximate Intervai Between Onsat and Death |
| , 0, | e axecuted ian and urial-transit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | 6 | b | | | | | | | | |
| Box 68760, | ath cartificate be axecuted ttanding physician and for usa as the burial-transit | lan/Medical | Cause (Disease or injury that initiated events rasulting in death) Last | d | Due to (| or as a conse | quence of): | | | | | | |
| ecords, P.O. | that tha dailed by the a | Physic | Part II. Other significant condition | ons contributing to | death but not re | sulting in the | underlying ca | iuse giv | ven in Part I. | | | | o the cause of death? |
| | aw requiras is been sign 2 should ba | Completed by | | | | | | | | 24a. Was an autopsy performed? | | av | dere autopsy findings vallable prior to impletion of causa death? |
| | Pa ata | Be Col | 25. Was case referred to medica | 1 | 1 Yes 2 No 1 Yas 2 No | | | | | | | | |
| on of Vita | ding Phys h. Aftar this funaral di | ertification: To B | examiner? XM Yes 2 No 27. Manner of Death 1 Naturel 5 Pendir 2 Accident investi | Hospitai: 1 = 28a. Date (Morgation | | ER/Outpatie | of 28 | Bc. Injui Woi | ner: 4 Nursing | Home 5 Resi | dence XXIO how injury occi | W A | touse the |
| Ο̈́ | i Di at o | O | 4 ☐ Homicide determ | nined 286. Place build | | LAMON | | | | 21885 N | wn, Stete) GWTOUNE | = Neuk | D STUDINGS (C |
| | Hospita 24 hours Funeral | dical | 29e. Certifier (Check only one) 1 Certifyir Madical | g Physician: To th Examiner: On the t and ma | e best of my kno casis of examina nner stated. | owiedge, dea ation end/or Ir | th occurred a nvestigation, | it the tir in my c | me, dete and plac ppinion, deeth occ | e, and due to the urred at the time, | date and piece | manner as s e, and due t | stated. o the cause(s) |

State Registrar 31. Date filed (Month, Dey, Year)

ALIG 27 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

111 Penn Street, Baltimore, Maryland 21201
32. Registrar's Signature

29c. License number

O.C.M.E.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the buriet-transit

Division of Vital Records, P.O. Box 68760,

Paul Julius Gray, Jr.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

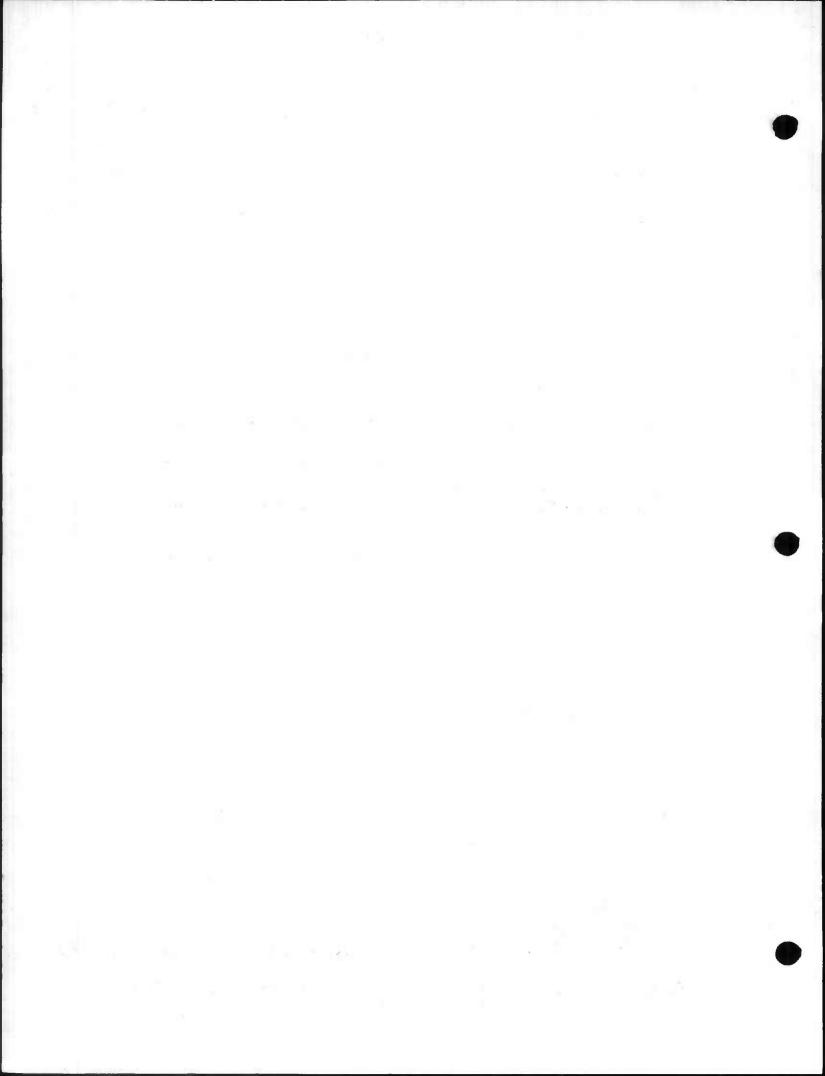
State of Maryland / Department of Health and Mental Hygiene 97 270

Certificate of Death

| | 1. Decedent's Neme | e (First, Middle, La | st) | | | | | 2. Dete of Dec | | | 3. Time of Death |
|----------------------------------|--|-----------------------------------|---|-----------------------------------|----------------------------|----------------------------------|--------------------------|---------------------------------|-------------------|------------|---|
| in ai | Julius 4e. Fecility Neme (// | f not institution, aiv | Paul e street end number) | | | Gray | Jr. lb. City. Town, or | Month Augus Location of Deeth | | 199 | |
| er | Part III and I carried | | | | | | | | | | |
| - | 25871 P. 5. Social Security N | | | e (In yrs. lest bi | irthdev) If L | Inder 1 Year | Chapt If Under 24 Hrs | | St. | | |
| | 217-34-04 | | M 2□F 60 | | | nths Days | Hours Min | Jan 22, | r, Year) | | nplece (State or Foreign untry) LIVLand |
| | Usuel Residence of | | | <i>y</i> | | - | | par 22, | 1737 | Lic | a y a no |
| | 10a. State | 10b. County | | 10c. City, Tov | vn or Location | า | | | | | 10d. Inside City Limits |
| to | Maryland | St. Mar | v's | Chap | tico | | | | | | 1 ☐ Yes 20 No |
| rec | 10e. Street end Nun | nber | | | | f. Zip Code | | | 10g. Citizen of V | Whet Cou | untry? |
| 0 | 25871 Phi | ilipThoma | s Lane | | | 20621 | | | U.S. | Α. | |
| era | 11. Merital Status | | 12. Was Decedent | Ever in U.S. | 13. Wes [| | ispenic Origin? (| Specify Yes or No- | | | ican Indlen. |
| F | 1 ☑ Never Marrie | ed 2 Married | Armed Forces? 1 ☐ Yes 2 🔯 1 | | If Yes | , specify Cube | n, Mexican, Puer | to Rican, etc.) | Bled | ck, White | , etc. |
| Š | 3 Widowed | | If Yes, Give Year or Dates: | | 1 🗆 Y | es 🏋 🗆 No | Specify: | | Specify | /: B | Black |
| 50 | | 15. Decedent's Ed | ducation | 16a | | Usual Occup | | | 16b. Kind of B | usiness/li | ndustry |
| ple | Elementery/Secon | ify only highest gra | College (1-4or t | 54) | (Give kind (life. DO N | of work done o OT use retired | during most of wo f) | rking | | | |
| E | 8th Grad | | College (1-401) | ,+, | Labo | rer | | | Farm | | |
| Be Completed by Funeral Director | 17. Fether's Name (| First, Middle, Last, | | | | | 18. Mother's Ne | me (First, Middle, | Meiden Sumen | 10) | |
| TOE | Julius | | Paul | | Gray, | Sr. | Nano | y | Ellen | | Curtis |
| | 19e. Informent's Ne | me/Reletionship (| Type, Print) | 19 | b. Melling Ad | dress (Street | end Number or R | ural Route Numbe | r, City or Town, | Stete, Z | ip Code) |
| | Joseph N. | Gray/Br | other | | P.O. B | ox 144 | , Chapti | co, MD | 20621 | | |
| | 20a. Method of Disp | | | 20b. Place | of Disposition | | | Dete | 20c. Location - | City or T | Town, Stets |
| | | ☐ Cremetion 3 ☐ 5 ☐ Other (Specif | Removel from Stete | | | | | 8/30/97 | Loopa | ~45~ | ···· MD |
| | 21. Signytfülje of Fur | | - 4 | Clarte | | ne end Addre | | 0/30/9/ | reona | rato | WII, MID |
| | To | 0 07 | 2/4 | 1. | | | | r Funera | | | |
| - | 23a Party Enter th | all T | dications thet caused | the death Do | P.O. | Box 2 | 70, Leon | ardtown, | Maryla | nd_ | 20650 Approximete |
| | shork, or hear | t failure. List only | one casse on each li | ne. | not ontor the | mode of dyni | g, oddir os dardio | o or respiratory or | 1031, | 1 | Intervel Between Onset end Deeth |
| | Immediete Ceuse (I | Finel | 0- 1 | 1 1 | М | | 1 | | | - | |
| | diseese or condition resulting in death) | | e. 120 | 6491 | e / ' | YOC | HR dir | L ENT | ARCIIC | シレ | |
| e | | | | Due to (or es e | consequenc | e of): | | | | | |
| E | | | b | | | 1 | | | | i | |
| xa | Sequentially list con if eny, leading to im cause. Enter Under | nditions, mediete | | Due to (or es e | consequence | e of): | | | | 1 | |
| an/Medical Examiner | Ceuse (Diseese or I that initiated events | Injury | c | | | | | | | | |
| ed ed | resulting in deeth) L | | | Due to (or es e | consequence | 9 O1): | | | | 1 | |
| 2 | | | d | | | | | | | | |
| | Death Other death | | | | | | | | | | |
| ys | Pert II. Other signifi | | ontributing to death b | ut not resulting i | in the underly | ring cause giv | en in Peπ I. | | | | to the cause of death? |
| 7 | | | AD. | | | | | ישי | ree 2□ No | 3 Pr | obably 4 Unknown |
| Completed by Physic | | | | | | | | 24a. Wes | an autoney | 24b. V | Vere eutopsy findings |
| ere | | | | | | | | perfor | med? | 0 | veileble prior to completion of cause |
| E E | | | | | | | | | | 0 | f deeth? |
| | | | | | | | | 1 🗆 Y | es 🎇 No | 1 | ☐ Yes 2☐ No |
| ge | 25. Was case referr examiner? | | Hospital: | | | 100 | | eth (Check only o | | | |
| 0 | Yes 2□1 | | Hospitel: 1 ☐ Inpatie | | | DOA Oth | 4 Li Nursing I | | enca 6 □Oth | | ify) |
| 0 | 27. Menner of Deeth | 5 Pending | 28e. Dete of Inju (Month, De | | Time of injury | 28c. Injury Work | k? | 28d. Describe h | ow injury occur | red | |
| cat | 2 Accident | investigation | | | M | | Yes 2 □ No | | | | |
| | 3 ☐ Suicide 4 ☐ Homicide | determined | 28e. Pleca of Injuding, etc | ury - At home, fa c. (Specify) | arm, street, fe | ectory, office | | 28f. Location (S City or Tow | | er or Ru | rel Route Number, |
| edical Certification: | 00: 0 :: | | | | | | | | | | |
| Ca | 29a. Certifier (Check only | | ysician: To the best of niner: On the basis of | exemination er | | | | | | | |
| Med | one) | / ` | end menner ste | | | | | | | | |
| | 29b. Signature and | A Certifier | do | ^ | | 29c. Licens | | _ | 29d. Date signe | | |
| | | 18 | M My | J | | DI. | 1285 | | 8- | 20 | - 97. |
| | 30. Neme end eddre | ess of person who | completed cause of d | eeth (Item 23a) | (Type, Print) | | | | | | |
| | William | D. Boyd, | II, M.D. | | | | Leonar | dtown, M | D 2065 | 0 | |
| 9 | 31. Dete filed (Monti | h Day YearT | 32 Rontetro | er's Signature | Rardal | l | | | | | |
| r | | AUG 28 | וטטון וככו | N AUTOMOCI | | | | | | | |

Stat

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97

| | | | | | | Ce | rtificate of | | Re | eg. No. | | |
|---------------------|--|------------------|--|---|-------------------------------|-------------------------|---|---|---|---|---------------------------|--|
| | Physic | ian | Decedant's Nama (First, Middle | | | | | | 2. Dete of Deet Month | h Dev | Year | 3. Time of Death |
| | /Medi | | Richard Euger | | | | | | Augus | + 21 | 1997 | 2:15 A.M |
| 2 | Exami | ner | 4a. Facility Name (If not institution | | | | | 4b. City, Town, or | | 4c. County | | |
| _ | | | Williams port 5. Sociel Security Number | | | 4 6 7 4 6 - 1 | If Under 1 Yea | William | • | | ringt | |
| L | Funeral Director | П | 220-05-6503 | 6. Sax 7. Ag | na (In yrs. las 78 | Yrs. | Months Days | | 8. Dete of Birth (Month, Day, Apれ、19, | 1979 | 9. Birthp Coun Mary | lace (State or Foreign Cand |
| | and * | Ì | Usual Rasidance of Decedant 10a. Stata 10b. County | | 10c. City, 1 | Town or Lo | ocation | | | | 1 | Od. Inside City Limits |
| | daryt f sho | ō | | ngton | , | | thsburg | | | | 1. | 1 □ Yas 2 No |
| | the 28a | rect | 10e. Street and Number | | | | 10f. Zip Coda | | 11 | 0g. Citizen of \ | What Coun | trv? |
| | 3a or | Funeral Director | 12830 Bradbw | u Ave. | | | | 783 | | | I.S.A | |
| | death | nera | 11. Maritai Status | 12. Was Decedant | Ever in U,S. | 13. | | Hispanic Origin? (S ban, Maxican, Puert | pecify Yes or No- | | e - Amaric | |
| Maryland 21215-0020 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show in jointy or other traumatic event, in Medical Examiner must be notified at once. | by | 1 Never Merriad Merria 3 □ Widowed 4 □ Divorced | Armed Forcas? Armed Forcas? Yas 2 If Yas, Giva Yeer or Datas: | | | If Yas, specify Cu 1 ☐ Yas 27 No | | o Rican, atc.) | Specify | ck, Whita, o | ite |
| 2-0 | 72 ho | ted | 15. Decedant' (Specify only highas) | s Education | | 16a. Dace | dant's Usuai Occu | upation | rking | 16b. Kind of B | usinass/Inc | dustry |
| 121 | ithin Ben | Completed | Elemantary/Secondary (0-12) | Collega (1-4or s | 5+) | lifa. | | a during most of wor ed) | King | Dav | a la | |
| 2 | led w lygier nt, th | | | 2 | | | Custo | | | Bai | | |
| anc | d off | Be | 17. Fathar's Nama (First, Middla, L | 97.5 | | | | | ma (First, Middla, N | | na) | |
| Ž | hould J Mer nerke | 70 | Grover C. Gar | | | | | | . Johnso | | | |
| Ma | d 2 sl th an 7 is r | | 19a. Informant's Name/Raiationsh Ruth B. Gaver | | | | | atend Number or Ru LU AUE. Sh | | | | Coda) |
| | Heall Heall orn 2 | | 20a. Mathod of Disposition | (wege) | 20b. Plac | e of Dispo | osition (Nama of | | | 20c. Location - | | wn Stata |
| Baltimore, | ages int of it. if it | | 1 X Burial 2 ☐ Crametion | | cem | etery, crar | natory or other pl | ' | 100 | | | |
| | artme ortani Injuri | | 4 Denation 5 Other (Sp | 1 | Smc | | ng Cemen 2. Nama and Addi | tery Aug. | 12525 Bra | | | g, Ma. |
| Ba | Depariment Important | | Con the said | f b | | Da | vis Fune | eral Home | 12525 574 | abury i | que. | |
| | - | | 23a. Part1. Entar tha disaasa, or | complications that caused | the death | Do not and | ar the mode of du | ing such as cardia | smuths bur | g, Ma. | 21/85 | Approximate |
| | Physician | | ahock, or haart teilura. List o | nly one cause on each li | na. | | | ing, order as our class | or raspiratory arre | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | Approximata Interval Between Onset and Death |
| П | /Medical | | Immediate Causa (Final disease or condition | . PNEU | MADAL | Δ | AND | SEPSIS | | | | 48 Howes |
| В | Examiner | | rasulting In death) | a. Theck | Due to (or a | s a consac | uence of): | 001017 | | | | TO HUMES |
| | p # | Iner | | . EMPH | YOUM | Α | | | | | | |
| | tificate be executed ig physicien end es the buriel-trensit | Examiner | Sequantially list conditions, | 6. | Due to (or e | s a consec | quance of): | | | | | |
| ő, | se exe | <u> </u> | Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) | | | | | | | | | |
| 68760, | hysic the t | edicai | Cause (Diseasa or injury that Initiated evants rasulting in death) Lest | 0 | Dua to (or as | a conseq | uanca of): | | | | | |
| | certific | υ/Me | | d | | | | | | | | |
| Вох | The law requires that the death certate has been signed by the ettending page 2 should be detached for use | Physician/M | Part II. Other significant condition | an anatoliusian ta danti b | | l | | and to Book I | con Bidas | | A 10 - 0 - 0 | |
| P. O. | the carbon archer | hys | Part II. Other aignificant condition | | | _ | ndariying cause g | IVON IN PAR I. | 230. Did to | | 3 ☐ Prot | the cause of death? |
| | es that igned to be det | by P | KECENT CER | EISRAL 7 | NFAR | 207 | | | A | 2 2 140 | 3 I FIOL | abiy 4 dikilowii |
| Records, | v require been sig should b | | GASTED INT | ZTINIAI | .1. | ADD. | HAGE | | 24a. Was ar | n eutopsy | | ara autopsy tindings |
| 900 | aw requisite the second | plet | CITY IEU ANT | SININ | Hen | UKK | MAGE | | perion | 1001 | COI | mpletion of cause death? |
| | The law ite has pege 2 | Completed | | | | | | | 1 □ Ye | s 2 No | 10 | Yes 2□ No |
| Division of Vital | | Be | 25. Wes casa ratarred to medical exeminar? | | | | | 26. Place of Dec | ath (Check only on | в) | | |
| <u>~</u> | Physic this ce | Tol | 1 Yas 2 No | Hospital: 1 ☐ Inpatie | int 2□ER | VOutpetler | nt 3□ DOA O | thar: 4 Nursing H | lome 5 Rasida | nca 6 🗆 Oth | ar (Specify | 1) |
| u c | fier th | | 27. Manner of Daath 1 ⊠Natural 5 □ Panding | 28a. Date of Inju (Month, Da | ry y Yaar) 28 | Bb. Tima of Injury | | ury et ork? | 28d. Describe ho | w injury occur | red | |
| sio | eeth. or: A | cati | 2 ☐ Accident investige | ation | | | M 1[| Yas 2□No | | | | |
| \leq | or Attending effer death. Director: After in by the fune | Certification: | 3 ☐ Suicida 6 ☐ Could no 4 ☐ Homicida determin | 28a. Placa of Injuding, etc | ury - At home c. (Specify) | a, farm, str | eet, factory, office | 9 | 28f. Location (Sti City or Town | | er or Rura | I Routa Number, |
| | urs e | | | | | | | | | | | |
| | To the Mospital or Attending Physician: The is within 24 brouts effect deeth. To the Funeral Director: After this certificate he completely filled in by the funeral director, page | edicai | 29e. Certifying (Check only one) Certifying Madical E | Physician: To the best of xaminar: On the bests of | axamination | dge, daeth end/or in | n occurred at tha t vastigation, In my | time, date end plece opinion, daath occu | , end due to the ca rrad at tha tima, da | iuse(s) end ma ita and plece, | nnar as st and dua to | ated. the causa(s) |
| | ithin o the o the o | Me | 29b. Signature and title of certifiar. | and manner ste | ered. | | 29c. Licar | nsa number | 29 | 9d. Data signe | d (Month, I | Dav. Year) |
| | F ≱ F 8 | | 15 | DAUP | M |) | D | 3370 | | A | | |
| • | | | 30. Name and addrass of person w | ho completed cause of d | eath /Item of | Sa) /Tuna | Print) | 2210 | | 1112115-7 | | 1771 |
| | | | Ted E House | > M T | 754 |) ^ | verloo | 3370 KDr. 1 | Boncl | nova | MD | 21712 |
| | Sta | te | 31. Date filed (Month, Day, Yaar) | | ar's Signeture | 8 | | | | 1 | | |
| | Registr | ar | AUG 25 19 | 197 Achie | Davidson | - Box | 1.02 · | | | | | |
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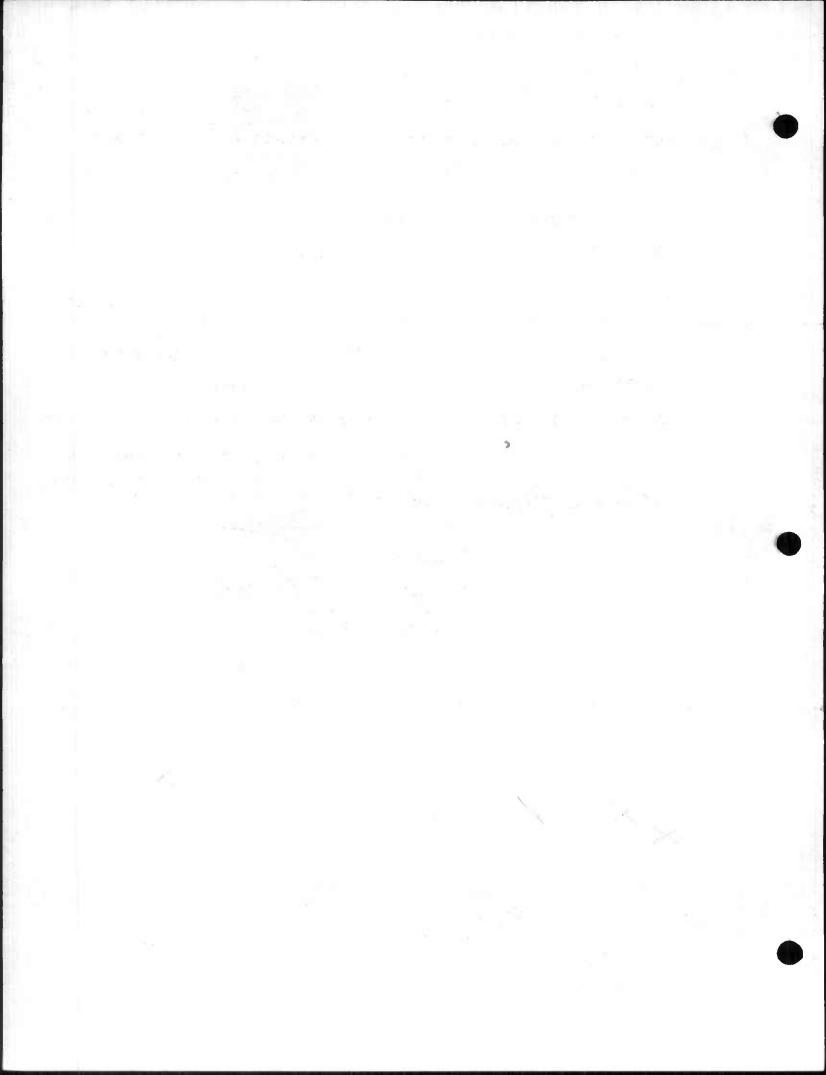
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| | | | | | | | | Cer | tificate | of | Death | | | Reg. No. | | |
|---------------------|---|------------------|--|-------------------------------|------------------------------------|------------------|-----------------------------------|---------------------|--|---------|----------------------------|----------------------|------------------------------------|-------------------------------------|-----------------------------|--|
| 100 | Dhusia | | 1. Decedent's Ner | | | | | | | | | | 2. Dete of De Month | eth Dey | Yeer | 3. Time of Death |
| | Physic /Medi | | EDW | ARD P | URNELL | HA | RRIS | | | | | | Augu | A CONTRACTOR OF THE PERSON NAMED IN | 199- | 1 1058 |
| | Exami | | 4e. Fecility Neme | | give street end no | | L CENTE | R | | 4 | | wn, or L | JRY | | nty of Death | |
| | Funeral | | 5. Sociel Security | | 6. Sex | | e (In yrs. lest bii | | If Under 1 | | If Under | 24 Hrs. | | rth | 9. Birth | nolece (State or Foreign |
| | Director | | 222-22 | -1926 | 1 ∏ M 2□F | | 61 | Yrs. | Months | Deys | Hours | Min. | (Month, D | sy, Year) 5, 36 | | nplece <i>(Stete or Foreign</i> untry) ELAWARE |
| | Pu . | | Usuel Residence | T | | | | | | | | | | | | |
| | h the Merylan r 28a-f show unotified at | or | 10a. Stete | 10b. County | SSEX | | 10c. City, Tow | | | | | | | | | 10d. Inside City Limits 1 ☐ Yes 🌪 ☐ No |
| | the noth | rec | 10e. Street and No | | 0021 | | | | 10f. Zip C | ode | | | 1 | 10g. Citizen | of Whet Cou | 41 |
| | th with | Funeral Director | RR 2 | вох | 317 | | | | | 19 | 9940 | | | | USA | |
| | Hems Items | Jue | 11. Maritel Stetus | | 12. Wes Dec Armed F | cedent orces? | Ever in U,S. | 13. V | Ves Deceder Yes, specify | t of H | ispenic Orl | gin? (Sp | ecify Yes or Ni Rican, etc.) | 0- 14.1 | Race - Amer Bleck, White | rican Indian, |
| 21215-0020 | 6 6 | by | | rled 2 Marri 4 Divorced | ed 1 ☐ Yes If Yes, G Year or | ive | No | | l□Yes 💥 | | | | | | 14 | WHITE |
| 2-0 | 72 hours | ted | (Sne | 15. Decedent | s Education | 1 | 16e | Deced | lent's Usuel (kind of work OO NOT use | Occup | etion | t of work | ina | 16b. Kind o | f Business/I | ndustry |
| 2 | within ene. than " | Completed | Elementery/Sec | | College | | i+) | lifa. L | | | | t or work | ing . | HOM | E | |
| 2 | other th | ပိ | 17. Fether's Nema | 7 | 2011 | _ | | | ROO | FEI | | 1 41 | | | | CTION |
| Maryland | permit. Peges 1 and 2 should be filed Department of Heelth and Mental Hyb Important: If Item 27 is marked orther any injury or other traumatic event, once. | To Be | ELWOO! | | | | | | | | 18. Moths | | e (First, Middle RGARET | | , | |
| lary | 2 shou and N | | 19a. informant's N | | | | 196 | | | | | | al Route Numb | | | |
| 2 | and eelith m 27 | | LAYTO | | RIS/UNC | LE | | | 305 E | | LEE 1 | DR. | | | | DE 19933 |
| Baltimore, | F of H | | 20e. Method of Dis | • | 3 □Removel from | State | | ry, crem | netory or other | er pled | | | Dete | | on - City or 1 | |
| tin tin | rtmer rtant: | | | 5 Other (Sp | | | MILLS | - | | | | | /8/97 | MILL | SBORG | D, DE |
| | Depared Important Information | | 21. Signature of F | uneral Service L | 100nsee | 1 | 1 (| / | Name and | | | LI | | | | RAL HOME |
| 36 | | | William Theischaus POB 502 GREENWOOD, DE. 19950 | | | | | | | | | | | | | |
| 8 | Dharalalan | | shock, or he | art failure. List o | nly one cause on | each fir | 10. | nos ente | ar the mode o | n ayın | g, such as | A | or respiratory i | screet, | 1 | Approximate Intervel Between Onset end Deeth |
| | Physician /Medical | | Onset end Deeth | | | | | | | | | | | | | |
| 28 | Examiner | ш | disease or condition resulting in daath) Oue to (so as a consequence of): | | | | | | | | | | | | | |
| 2 | ₽ ≈ | ner | | | | 110 | while | L | 1 | P | sil | 411 | Tako | 2 | | |
| 22 | ie death certificate be executed the ettending physician end hed for use as the bunel-transit | Examiner | Sequentially list of | onditions, | r | A | Ende to (or as a | onseq | uence of): | 1 | 10 | | ~~ | * | | |
| 300 | be ex iclan bunel | | Sequentially list of if eny, leading to in cause. Enter Und Causa (Disaase of that initiated evant | erlying r Injury | G | C | reelle | les | - 0 | U. | 5 | | | | | |
| . 3 58760 | phys phys | edical | resulting in death) | Lest | | | Due to (or an a | peano | ience of): | | | | | | | |
| SX | certif nding use a | ₹ | | | d | | | | | | | | | | | |
| _ 5 ° 8 | death e etter ed for u | cia | Pert II. Other eigni | ficent condition | e contributing to | laath hi | ut not requiting in | the un | dod ion on | na ahi | on la Dord I | | 22h Did | tehana uan | o a m tulbu uta | to the serves of death (|
| 40 | p > 5 | Physician | Pertil. Other eight | meant condition | re contributing to c | eath bt | at not resulting if | i the un | ideriying cau | se giv | en in Perti | • | | Yes 2 N | | to the cause of death? |
| S. S. | s thet gned b | by P | | | | | | | | | | | | 201 | 0 0011 | Joseph Taranta Maria |
| Edubar I Records | requires een sign hould be | | | | | | | | | | | | 24e. Wes | an autopsy | 24b. V | Vere eutopsy findings veileble prior to |
| 300 | lew re as be 2 sh | pie | | | | | | | | | | | port | omieo : | C | completion of cause of death? |
| Edub | vicien: The lew certificate has rector, page 2 | Completed | | | | | | | | | | | 10 | Yes 2 N | 1 | ☐Yes 2☐No |
| /ita | clen: ertific ector, | Be | 25. Wes case rafa exeminer? | rrad to medical | | | . / | | | | 26. Place | of Deet | h (Chack only | ona) | | |
| of | this ald | ပ္ | 1 ☐ Yes 2 | No | | Inpatie | | tpetien | | Oth | 4 LI NU | Y | me 5 Res | | | ity) |
| no | Attending Physician: or death. ector: After this certific by the funeral director, | ion | 27. Manual of Dea | 5 Panding | | of Injui | Year) 28b. | Time of njury | M 280 | Worl | | | 28d. Describe | how injury oc | curred | |
| isi | death death ctor: y the | licat | 2 ☐ Aöcident 3 ☐ Suicide | Investig | ot be | e of ini | ury - At homa, fa | rm etre | | | Yes 2□ | | 28f Location | Street and No | mhar or Pu | ral Route Number, |
| οį | offer all or A offer of in b | Certification: | 4 ☐ Homicide | datemi | build | ling, etc | . (Specify) | im, şue | et, lectory, c | 11100 | | | City or To | wn, Stata) | mber or riu | ar rioute rearriber, |
| | To the Hospital or Attending Physician: The leverthin 24 hours effer death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | edical C | 29a. Certifier (Check only one) | 1□ Certifying 2□ Medicai E | Physician: To the xaminer: On the | a best of | of my knowledge examination en | , daeth d/or inv | occurred et estigetion, in | the tin | ne, dete en pinion, dee | d place, th occur | end due to the red et the time, | ceuse(s) end date and ple | mennar es | steted. to the ceusa(s) |
| | offin offin ompl | Me | 29b. Signeture end | titla of certifier | //// | | | | 29c. L | icens | e number | | | 29d. Dete sig | ned /Month | , Day, Year) |
| | / | | • | 119 | PAGE | - | 7 | | 1 | 48 | 22 | / | | 2 | 16/9 | 7 |
| | | | 30. Neme and add | ress of person w | ho complated cau | se of da | aeth (Itam 23a) | Type, f | Print) | 7 | ed | | alsburg | + | 1 | |
| | - 01 | • | 31. Dete filed (Mor | | | | 262 er's Signature | | ighmm | (| na. | 51 | HISPHIG | , mo | | |
| | Sta Registr | | AUG 2 | | Jalia Davie | _ | - | | | | | | | | | |
| | | | | 1. | / | 2001 | - VIL | | | | - | | | | | |

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Deeth **Physician** Month George Henry 1997 3:12 AM. Holt August /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** St. Masy's Hospital

5. Sociel Security Number 6. Sex St. Marys Leonardtown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Yeer) 7. Age (In yrs. lest birthday) Birthptece (State or Foreign Country) **Funeral** Deys Months 18 M 2 □ F Yrs. Director 59 214-36-3387
Usuel Residence of Decedent November 28, 1937 Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylar Depertment of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f show the property injury or other traumstic event, the Medical Examiner must be notified as once. Director 1 Yes 2010 MD St. Mary Hollywood 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Rt. 2 Box 27 20636 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status 14. Race - American Indian, Bleck, White, etc. 1 ☑ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 Widowed 4 Divorced **Black** Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) Chef Union 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be Joe Connors Rosalie Holt 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 44335 Miles Village Dr., Hollywodd, MD 20636
ce of Disposition (Neme of Dete 20c. Location - City or Town, Ste Francis P. Bonds/Cousin 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete to Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Charles Memorial Gardens 8/20/97 4 ☐ Donetion 5 ☐ Other (Specify) Leonardtown, MD 21. Signature of Funeral Service Licer 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, MD 20650

ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events e to (or as a consequence of) HOLT GEORGE HENRY Division of Vital Records, P.O. Box 68760, The law requires that the death certificate be Physician/Medical 2 Due to (or as a consequence of): Part II. Other significant conditions contributing to 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 XNo 3 Probably 4 Unknown ģ Completed 24b. Were autopey findings evallable prior to 24s. Was an autopsy performed? in of ogu certificate has 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 XNo Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To Minpatient 2□ ER/Outpatient 3□ DOA 붛 27. Manner of Deat 28b. Time of 28d. Describe how injury occurred Affec 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) NO U atter A 4 D Homicide To the Hospital o within 24 hours at To the Funeral D Cartifying Physician: To the best at my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the Cartifying Systemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and granner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title 29c. License number 29d. Date signed (Monty, Day, Year) 30. Name and address JAMES JARBOE M.D. LEONARDTOWN, MD. 20650 dia Dander Ravall State AUG 20 Registrar

DHMH 16 Rev 6/95

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| Type or Print in Black Indelible Ink. Assur | e All Copies Are Legible. | |
|---|---------------------------|----------------|
| State of Maryland / Department of Health at Certificate of Death | nd Mental Hygiene 97 2 | 7050 |
| st) | 2. Date of Death | 3. Tima of Dee |

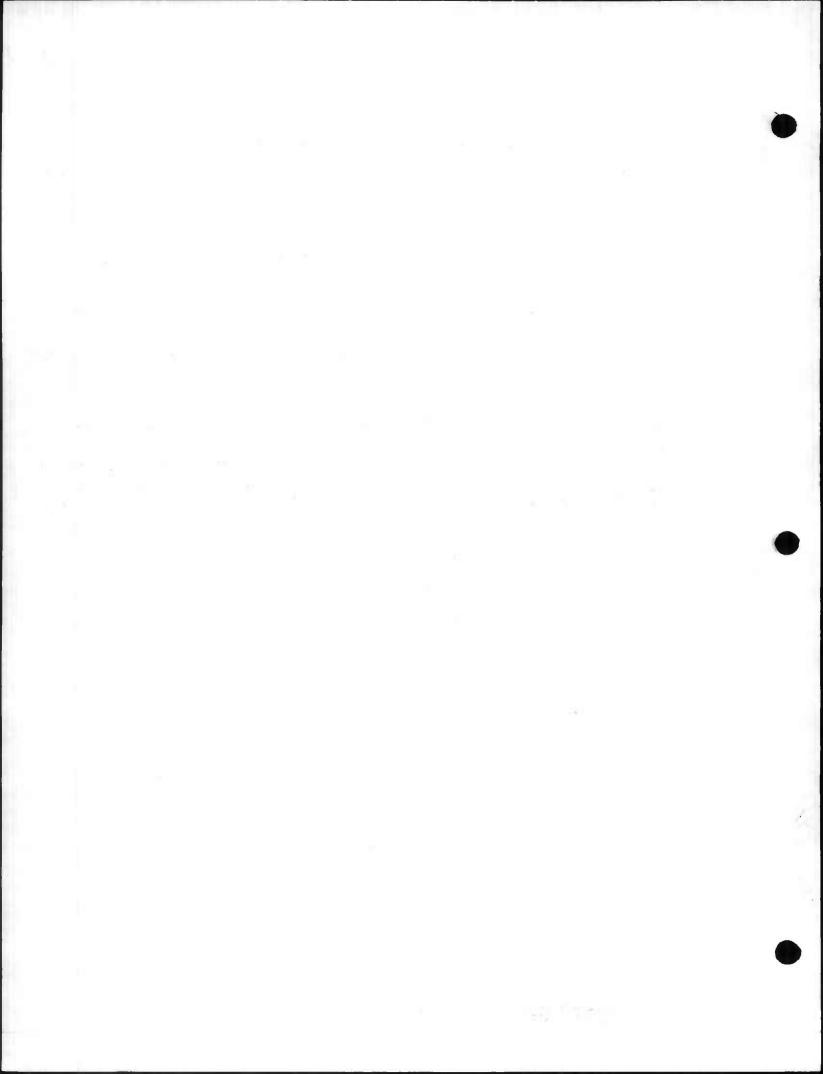
Registrar **DHMH 16 Rev 6/95**

AUG 27 1997

Lulia Davidson

1. Decedant's Nama (First, Middla, La **Physician** Ab. City, Town, or Location Deeth 4c. County of Death DITHEIL MAE /Medical 4a. Fecility Nama (If not Institution, giva street and number) **Examiner** WASHINGTON COUNTY HOSPITAL HAGERSTOWN
if Undar 24 Hrs. 8. Da WASHINGTON 8. Data of Birth (Month, Dey, Yaar)
DEC. 18, 1918 5. Social Sacurity Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Birthpleca (Stata or Foreign Country) **Funeral** 1 ☐ M 2 🛛 F Months Days Hours Min. Yrs. 78 Director 215-14-1870 MARYLAND Usual Rasidance of Dacedant the Maryland 10e. Stata r 28a-f show 10b. County 10c. City, Town or Location 10d. Insida City Limits 1X Yes 2 □ No Directo MARYLAND WASHINGTON **BOONSBORO** 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 6 the Medical Examiner must be 238 8 FORD AVENUE 21713 U.S.A. Funeral Hems ? 12. Was Dacedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No Was Dacedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) Raca - Amarican Indian, Black, Whita, atc. 11. Marital Stetus filed within 72 hours after 1 ☐ Nevar Married 2 ☑ Marriad Baltimore, Maryland 21215-0020 6 If Yas, Giva Yaar or Datas: 1 ☐ Yes 2 X No Specify: by Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", WHITE Be Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decadant's Education 16b. Kind of Businass/Industry (Specify only highast grada complated) no mental Hygiene. 127 is marked other than "ny traumatic even. Elementery/Secondery (0-12) Coilege (1-4or 5+) INSPECTOR CLOTHING MANUFACTURER 17. Father's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middle, Meidan Sumama) Pages 1 and 2 should be fill ment of Health and Mental H lant: If item 27 is marked oth WILLIAM EBERSOLE 2 LOLA SHUMAKER 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) nt of Health a : If item 27 is or other tra CYNTHIA K. SHAW/DAUGHTER 135 LAKIN AVENUE, BOONSBORO, MARYLAND 21713 20a, Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Crametion 3 ☐ Ramoval from Stata permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Othar (Specify) BOONSBORO CEMETERY 8/30/97 BOONSBORO, MARYLAND 21. Signature of Funeral Service Licensee 22. Nama end Addrass of Facility 7606 Old National Pike Paul M. Dean BAST FUNERAL HOME Boonsboro, Maryland 21713 23a. Pairt1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximata Intarval Batween Onsat end Daeth **Physiclan** /Medical Immediata Cause (Final Cardiac turen u mi'm disaasa or condition rasulting in death) Examiner Due to (or as e consequanca of): Examiner Kland consentin (wax Sequentially list conditions, if any, leading to Immediata causa. Entar Underlying Causa (Disaasa or Injury that initiated evants rasulting in daath) Last Dua to (or as a consequance of): Box 68760 Antemon clerking GLA 24 8 Physician/Medical 2 Dua to (or as a consaquence of): P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown oblinchin Chroniz. Division of Vital Records. þ 2 malliting Completed 24b. Were eutopsy findings available prior to complation of cause of deeth? 24a. Was en autopsy performed? Diahty page 2 1 Yas 2 9No 1 ☐ Yas 2 ☐ No Be 25. Was cesa rafarred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidance 8 Other (Specify) 1 Yas 2 4 No 1 ☐ Impatiant 2 ☐ ER/Outpatiant 3 ☐ DOA Certification: To this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Affor Attending 1 Natural 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 2 Accident after death 6 Could not be detarmined 3 Sulcide 28a. Plece of Injury - At home, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 6 To the Hospital within 24 hours a To the Funeral C completely filled Hospital edicai factifying Physician: To tha best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner es stated.

2 Madical Examiner: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the time, data and place, and dua to the cause(s) and manner stated. 29e, Certifler 29b. Signature and titla of certifiar 29c. Licensa number 29d. Data signed (Month, Dey, Year) - But mo P (8019 Aus 27, 1992 30. Nema and eddress of person who completed cause of death (Item 23a) (Type, Print) Dr. Datta 334 31. Data filed (Month, Day, Year) 32. Ragistrar's Signatura State



State of Maryland / Department of Health and Mental Hygiene 97 27051

| | | | | | | Cert | ificate o | f Death | , | Reg. No. | 1 6 | . 1001 |
|-------------------|---|---------------|---|---|------------------------------|-------------------|-----------------------------------|--------------------------------|---|----------------------------|---------------------------|---|
| П | Dhusia | | 1. Decedent's Neme (First, Middle, Le | st) | | | | | 2. Dete of De | | Yeer | 3. Time of Deeth |
| | Physic /Medi | | KATHLEEN DELORES | HETZEL | | | | | | 26, 19 | | 12:30 A.M |
| | Exami | | 4e. Fecility Neme (If not institution, give | e street end number) | | | | 4b. City, Town, | or Location of Deet | h 4c. County | of Death | |
| | | | 19215 Porterstow | n Road | | | | Keedys | | Wa | shing | ton |
| | Funeral Director | | 217-20-0574 | ex 7. Ag □ M 2 F | ge (In yrs. last b 65 | Vrs. | If Under 1 Year Months Day | | in. (Month, De | th by, Year) 2, 1931 | | plece (State or Foreign stry) rland |
| | and w | | Usuel Residence of Decedent 10e. Stete 10b. County | | 10c. City, To | wn or Loc | ation | | | | 1 | 0d. Inside City Limits |
| | Sa-f sho | Director | Maryland Washing | ton | Boon | | | | | | | 1□Yes 2□No |
| | th with th | ai Dire | 10e. Street end Number 705 Orchard Mano | r Drive | | | 10f. Zip Code 21 | 713 | | 10g. Citizen of U. | What Coun | try? |
| 020 | within 72 hours efter deeth with the Maryland iene. Then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at | by Funeral | 11. Maritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Wes Decedent Armed Forces? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{If Yes, Give} \) Year or Detes: | | | as Decedent of Yes, specity Cu | | (Specify Yes or No erto Rican, etc.) | | ce - Americ ck, White, | etc. |
| 5-0 | 72 hc | eted | 15. Decedent's Ed (Specify only highest gra | fucation | 16 | e. Decede | nt's Usuel Occ | upetion | vodkina | 16b. Kind of B | usiness/inc | Justry |
| 21215-0020 | d within piena. r than t | Completed | Elementery/Secondary (0-12) 10 Years | College (1-4or | | | NOT use retil | e during most of v | voiking | Garmen | t Man | ufacture |
| | be filed ital Hygid d other event, ti | BeC | 17. Fether's Neme (First, Middle, Lest) | | | | | | leme (First, Middle | | | uraccure |
| Maryland | d 2 should be f th and Mental I 7 is marked of traumatic eve | TOE | Edward McComas Ki | | 10 | h Maiting | Addrage (Stra | | M. Myers | | State Zin | Codel |
| | 70 55 75 # | | Marilee Combs, Da | | | | | | ad, Keedy | | | |
| ē, | -755 | | 20a. Method of Disposition | augireer | | | ition (Neme of atory or other p | | Date | 20c. Location | | 21756 wn, Stete |
| altimore, | 904 | | 1 XBurial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify | 1) | | | | | st 29, 19 | 97 Boon | sboro | , Maryland |
| Bal | permit. Pag Department Important: I any Injury o | | 21. Signeture of Funerel Service Licen | 82- por | with. | | Neme end Add | ress of Fecility ERAL HOME | | ld Natio | | Pike d 21713 |
| | | П | P. Steven Dan: 23a. Pert1. Enter the disease, or comp shock, or heart fellure. List only | plicetions that cause one ceuse on each li | d the death. Do | | | | | | Lyran | Approximete fntervel Between Onset end Death |
| X | Physiclan /Medical | | Immediete Ceuse (Final | | 4 | , , | 4 | 0 | | | | |
| 1 | Examiner | ш | diseese or condition resulting in death) | θ | | | | Precos | - Cane | <u></u> | | 8 month. |
| | | ē | | | Due to (or as a | a consequ | ence of): | | | | i | |
| | cata be executed physician and s tha bunal-transit | Examiner | Sequentially list conditions, | b | Due to (or as a | consequ | ence of): | | | | | |
| ,09 | death certificata be executed e attanding physician and ed for use as tha bunai-transi | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury | C | | | | | | | | |
| 68760, | ntificata ng phys e as tha | ledicai | that initiated events resulting in deeth) Lest | | Due to (or es a | conseque | ence of): | | | | | |
| Вох | eath cert attandin for use | In/M | | d | | | | | | | | |
| | death e atte | sician | Pert II. Other eignificant conditions of | ontributing to death b | ut not resulting | In the unc | deriving cause (| iven in Pert I | 23b. Did | tobacco usa co | entribute to | the cause of death? |
| P.0 | that the death ned by the attar s detached for t | Physi | • | | ar rior room, ing | 11110 0110 | ortying occusor (| grott art of t. | | | | pably 4 ☐ Unknown |
| of Vital Records, | aw requires is been sign 2 should be | Completed by | | | | | | | 24e. Wes | en eutopsy ormed? | eve | ere eutopsy findings bilable prior to mpletion of cause deeth? |
| 8 | | Ю | | | | | | | 1 🗆 | Yes 2 No | 10 | Yes 2□ No |
| ita | ysician: The is certificate director, per | Be | 25. Was case referred to medical | | | | | 26. Place of D | eath (Check only | one) | | |
| 5 | 5 00 0 | To I | examiner? 1 ☐ Yes 2 ☑ No | Hospitel: 1 Inpatie | ent 2 ER/C | Outpetient | 3□ DOA C | other: 4 Nursing | Home 5 Resi | dence 6 □Oth | ner (Specify | 1) |
| o uo | Attending Ph ir death. ector: After th by the funeral | | 27. Menner of Death 1 Neturel 5 Pending 2 Accident Investigation | 28e. Dete of Inju (Month, De | y Year) 28b. | Time of Injury | 28c. Inj W M 1[| ury at ork? ☐ Yes 2 ☐ No | 28d. Describe | how injury occur | rred | |
| Division | To the Hospital or Attending F within 24 hours efter death. To the Funeral Director: After complataly filled in by the funer | ertification: | 3 Sulcide 6 Could not be determined | 28e. Placa of Inj building, et | ury - At home, to. (Specify) | ferm, stree | et, factory, office | 9 | 28f. Location (City or To | | ber or Rure | l Route Number, |
| _ | Hospital 24 hours Funeral italy filled | edicai C | 29a. Certifier 1 ☐ Certifying Ph | ysician: To the best niner: On the basis o | of my knowledg | je, death o | occurred et the | time, dete end pla | ce, end due to the | ceuse(s) and made | anner as st | eted. |
| | To the Nithin 2 To the F | Med | onej | end manner st | ated. | | | | | | | |
| | To Mile | | 29b. Signeture end title of certifier | 10 | , | | | nse number | | 29d. Dete signe | | |
| | | | Muchael & | und | m | | | 41667 |) | 8.2 | 7.9- |) |
| | | | 30. Name and eddress of person who a | completed cause of c | eath (Item 23a) | (Type, P | rint) redsea | 1 Comos | Suite | 130 1 | theo. | shun, mp. |
| | Sta | te | 31. Dete filed (Month, Day, Year) | 32. Registr | er's Signature | ميا | | | | | 1 | |
| | Registi | ar | AUG 271 | 991 | ha Davide | on-P | ndelle | | | | | |

State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month MATTHEW ROY HOVIS AUGUST 25, 1997 0408 /Medical 4e. Facility Name (If not institution, give street and number) 4b City Town or Location of Deeth 4c. County of Death Examiner WASHINGTON COUNTY HOSPITAL ICU HAGERSTOWN WASHINGTON 5. Social Security Number If Under 1 Yeer If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1XM 2□ F Days Hours 25 210-60-2616 Director Jun 29, 1972 Waynesboro, PA Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d, Inside City Limits 28a-1 show must be notified at Director 1 ☐ Yes 2 ☐ No Franklin Waynesboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 312 Geiser Avenue 17268 USA Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Status should be filed within 72 hours after of Mental Hygiene.
marked other then "natural", or itel 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 18a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) 12 Cook Restaurant 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) Be Pages 1 end 2 should be and Mental Richard L. Hovis Linda K. Shade 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Ralationship (Type, Print) nt of Health a : If item 27 is or other trai Richard L. HOvis, Father 312 Geiser Ave Waynesboro PA 17268 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Buriel 2 🛣 Cremation 3 🖾 Removal from Stata Omberland Valley Crematorium 8/26 Wavnesboro PA 17268 4 ☐ Donation 5 ☐ Other (Specify) 21. Environ of Funeral Service License 22. Name and Address of Fecility GRove Funeral Home, Inc. Ames A. 50 S Broad ST Waynesboro PA Bower sox 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tock, or heart failure. List only one cause on each lina. Approximata Interval Batw Onset end Death **Physician** /Medical Immediate Cause (Final wound to Head disease or condition resulting in death) Gunshot Examiner Due to (or as a consequanca of): Examiner physician and s the bunal-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 220 No 3 | Probably 4 | Unknown signed b þ page 2 should Be Completed 24b. Were autopsy findings evellable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 □ No 1.27Yes 2□ No Hospital or Attending Physician: 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After 1 Natural 5 Pending death. 0023 AM 1 Yes 2.PTNo investigation 2 Accidant 8-25-97 Subject was Shot 281. Location (Street and Number or Aural Route Number, City or Town, State) 33 F. washing ton within 24 hours after deat To the Funeral Director: completely filled in by the 3 ☐ Sulcide 4 ☐ Homicida 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) in by Behind building Hagerstown, Maryland 29a. Certifian (Check only one) Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceusa(s) and manner stated. To the 29b. Signature end title of certifiar 29c. License number 29d. Date signed (Month, Day, Year)

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

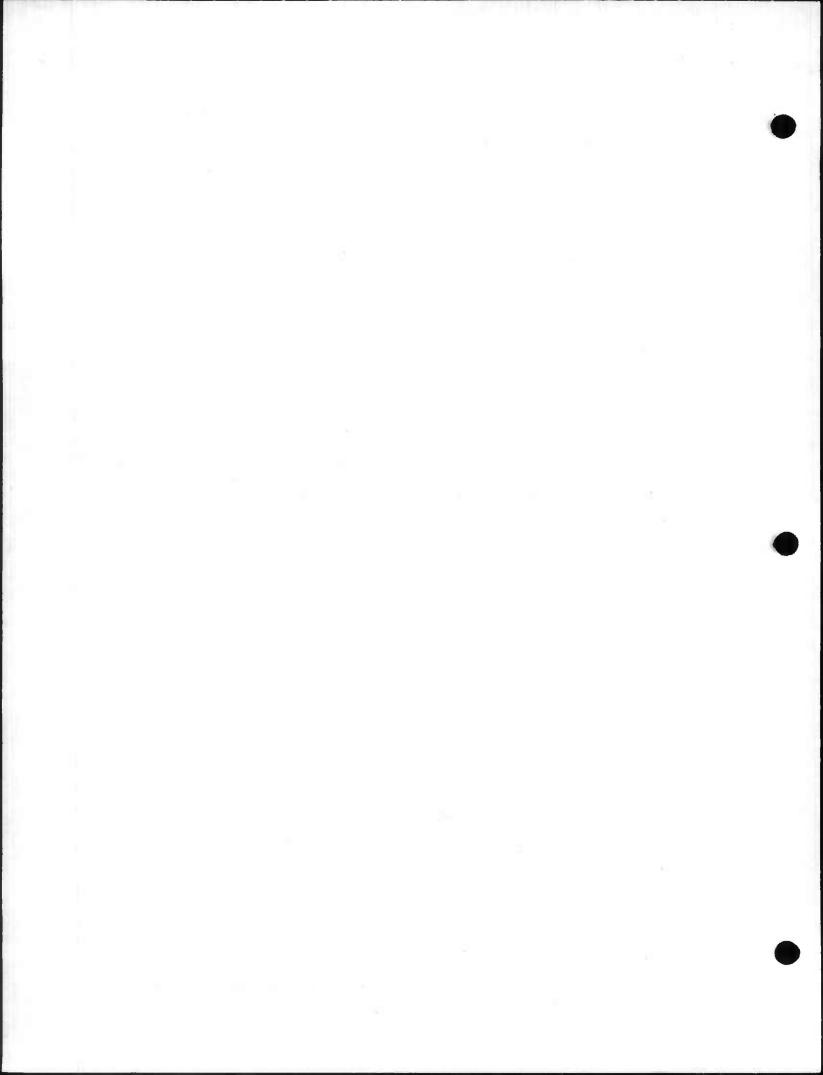
State Registrar

30. Nama and address of person who complated ceusa of daath (Item 23a) (Type, Print)

Register's Signature

Stephen Radentz, M.D.

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 97

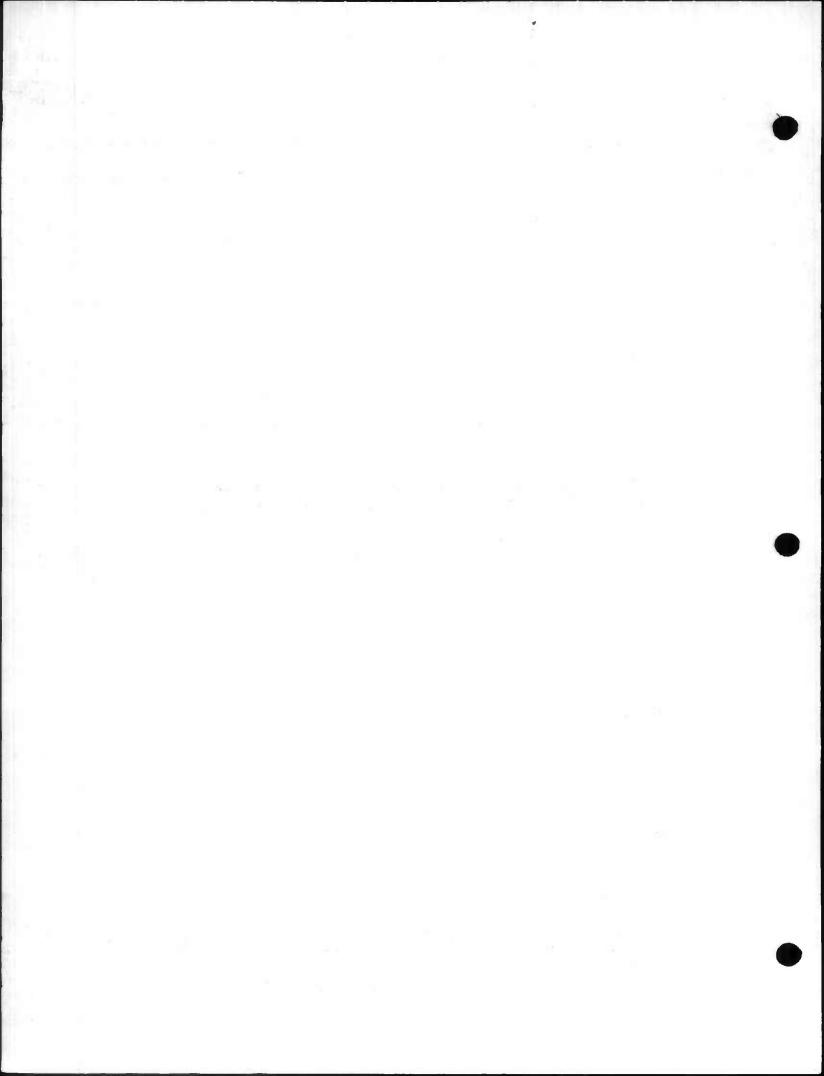
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month Yeer James Andrew Jordan 7:50 AM 1997 July /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Fort Washington Hospital Fort Washington Prince George If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Deys Hours 1፟፟፟∭ M 2□ F Yrs. Director June 15,1907 Maryland 578-84-3762 90 Usuel Residence of Deceden with the Maryland 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23e or 28a-f show traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director St. Mary's Ridge 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? P.O.Box 188, Fresh Pond Neck Rd. death Funeral 20680 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mantal Hygiene. Important: If Itam 27 is marked other than "natural", or thei any injury or other traumatic event, the Magicial Examination. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: à Specify: 3 ☼ Widowed 4 □ Divorced Black Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 5th Waterman Seafood 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Thomas Jordan Becky Fenwick 19e. Informent's Neme/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Thomas Arron Jordan/Nephew P.O.Box 47, 45451 Happyland Rd., Callaway, MD 20620 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 Buriel 2 Cremation 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 8/1/1997 Leonardtown, MD Charles Memorial Gardens 21. Signeture of Funeral Service Liceni 22. Name end Address of Fecility Mattingley-Gardener Funeral Home, P.A. 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. P.O.Box 270, Leonardtown, MD 20650 Approximete Interval Between Onset end Deeth **Physiclan** orgestie Harn Follupe /Medical Immediate Ceuse (Finel diseese or condition resulting in deeth) **Examiner** attending physician and for use as the burial-transit be executed Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting In deeth) Lest Records, P.O. Box 68760. Physician/Medical Due to (or es e consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No been signed by should be datac 3 Probably 4 Unknown MENTIF by 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24e. Wes an eutopsy performed? Completed page 2 certificate has 2 1 No 1 Yee 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 3 ☐ ER/Outpetient 3 ☐ DOA To the Hospital or Attanding Phys within 24 hours after death. To the Funeral Director: After this filled in by the funeral 27. Menner of Deeth 28c. Injury et Work? 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Neturel 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner es steted. completaly 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeture # arof certifier 29c. License number 29d. Dete signed (Month, Dey, Year) D-24945 30. Neme and address of person cause of deeth (Item 23e) (Type, Print) Michael Levin, 7801 Old Branch Avenue, Suite 409, Clinton, MD 20735

Register's Signature Randall

DHMH 16 Rev 6/95

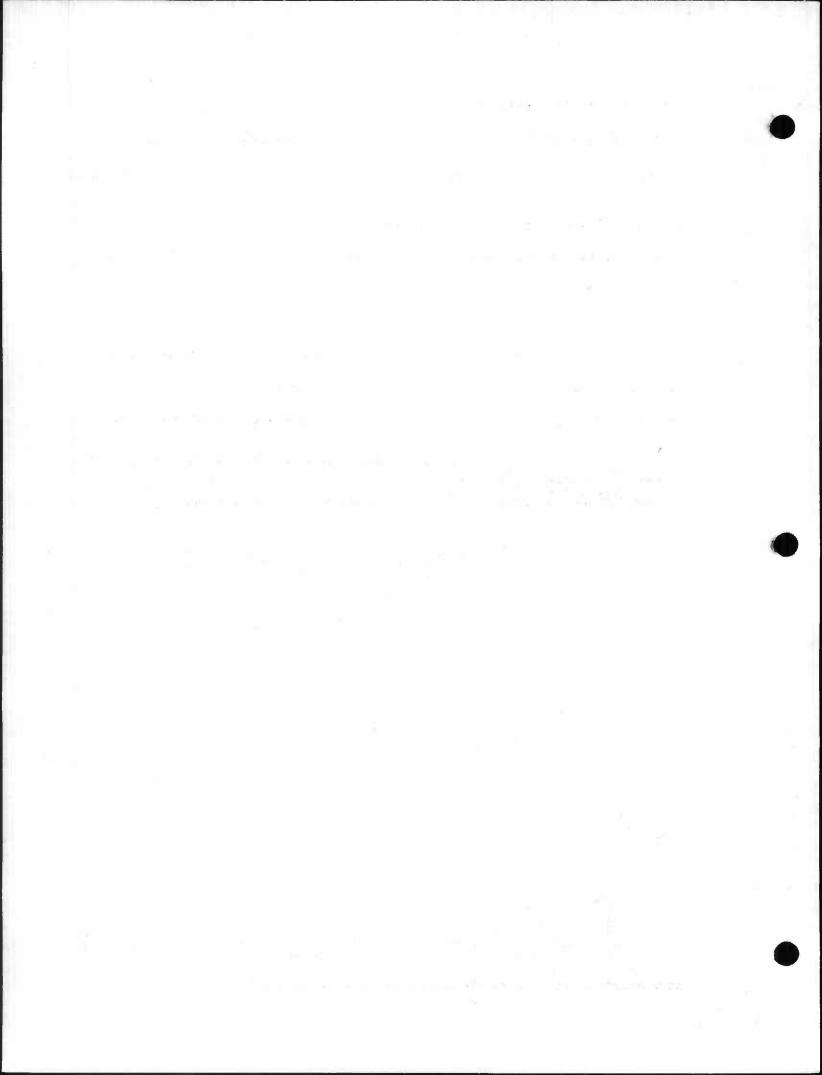
State Registrar

31. Date filed (Month, Dev. Yeer)



State of Maryland / Department of Health and Mental Hygiene 97

| | | | | | | Ce | rtificate d | of Deat | h | | Reg. No. | 51 | 21001 | |
|--------------------------------|--|--------------------|--|--|--|--|--|-----------------------|---------------------------------|---|--------------------------------|---|---------------------------------|--|
| Physician | | an | 1. Decedent's Name (First, Middla, Last) | | | | | | | 2. Date of Death Month Day Year | | | 3. Time of Death | |
| | /Medi | | Edward Felix | Kalendek | | | | | | Augu | | 1997 | 3:20 p.m. | |
| \rightarrow | Exami | | 4a. Fecility Neme (If not institution, git | | | | | 4b. City, Town, or Lo | | | county of Death | | | |
| | | | St. Mary's Nursing Center Leon | | | | | | | | | . Mary | | |
| | 72 hours effer deeth with the Maryland naturel', or liens 23s or 28s4 show contract or notified at the last of the liens o | Funeral Director | 5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. 212-05-7712 Usual Residence of Decedent | | | est birthday) II Under 1 Year II Under 24 Hrs. Months Days Hours Min. | | | | 8. Date of Birth (Month, Day, Year) | | 9. Birthplace (Stata or Foreign Country) Maryland | | |
| | | | | | | | | | | | | 10d. Inside City Limits | | |
| | | | Maryland St. Mary's Holly 10e. Street and Number | | | | | 1 ywood 10f. Zip Code | | | | 1 ☐ Yes 2 ☐ No 10g. Citizen of What Country? | | |
| | | | 26057 Sotterley Heights Road 20636-0536 | | | | | | | | - | d Stat | | |
| | | ner | 11. Marital Status | 12. Was Decedent B | Was Decedent Ever in U,S. Armed Forces? | | 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuben, Mexican, Puerl | | | ecify Yes or N | 0- 14. | 14. Rece - American Indian, Biack, White, etc. | | |
| 020 | | by | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 Yes 2 N If Yes, Give Year or Dates: | lo | 1 ☐ Yes 2 ☐ No Specify: | | | | rican, etc.) | | Specify: White | | |
| Baltimore, Maryland 21215-0020 | "natural", | eted | 15. Decedent's Education (Specify only highast grada completed) | | | 16a. Decedent's Usuel Occupetion (Giva kind of work dona during most of working | | | | | 16b. Kind of Business/Industry | | | |
| | 2 should be filed within end Mental Hygiene. Is marked other than aumatic event, the M | To Be Completed | Elementary/Secondary (0-12) | College (1-4or 5 | +) | life. DO NOT usa retired) | | | | 9 | | | | |
| | | | 17. Fether's Name (First, Middla, Last | 4 | | Inorg | ganic Cl | | | o /Eirot Middle | | Indus | try | |
| | | | Felix Kalendek | | 18. Mother's Name (First, Mic Cecilia Barly | | | | | | | | | |
| | | | 19a. Informant's Name/Relationship | Type, Print) | | 19b. Maili | ng Address (St | | | | | wn State Zi | n Code) | |
| | | | Estelle C. Kalendek, | | | | Box 536 | | | | | 20636 | | |
| | Heelth Hem 27 other tr | | 20a. Method of Disposition | | 20b. Plac | ce of Dispo | sition (Nama o | f nlace) | | Date | 20c. Locati | on - City or T | own, State | |
| | permit. Peges 1 end Department of Heelth important: If item 27 any injury or other tr once. | | 129 Burial 2 Ucremation 3 Hemoval from State | | | matary, cramatory or other place) Holy Redeemer Cemetery 8 | | | -16-97 | Baltimore, Maryland | | | | |
| | | | 21. Significant Service the service that the the service th | | | | | | | | | | | |
| | 88 3.68 | | Foreign Brinsfi | eld Jr. MO | 052 | 22 | 955 Holly | vwood Re | | | | - | | |
| | or Attending Physician: The law requires thet the death certificate be executed by the fet death. Director: After this certificate hes been signed by the ettending physician end in by the funeral director, page 2 should be deteched for use as the buriel-transit in by the funeral director. | | 23e. Pert 1. Enter the disease, or com shock, or heart failure. List only | | the death. | Do not ent | er the mode of | dylng, such | as cardiac | or respiretory | errest, | | Approximete Interval Between | |
| | | | are row the arrow that | | 0 | | | | | Λ | | | Onset and Deeth | |
| 11 | | | Immediete Cause (Final disease or condition resulting in death) a. Carelo Sulmnay Failure Due to (or as a consequence of): | | | | | | | nrs | | | | |
| , | | 7 | | | | | | | | | | | | |
| | | Examiner | - | n ->6 | Pi | L | 4 | 11 | | | | | une | |
| | | Exa | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury | Out to (or a | as a consequence of): | | | | | | 1 | 1 and | | |
| 68760, | | cal | that initieted events | s a consec | a consequence of): | | | | | | Dr.C | | | |
| | | Medical | resulting in death) Lest | | | | | | | | | | | |
| S. Box | | | - | d. | | | | | | | | | - | |
| | | Physician/ | Part II. Other eignificant conditions of | ontributing to death bu | t not resulti | ng in the u | nderlying cause | e given in Pa | rt I. | 23b. Did | tobacco use | contribute t | o the cause of death? | |
| P.0 | | To Be Completed by | | | | | | | 1 Yes 2 10 3 Probably 4 Unknown | | | | | |
| ds, | | | | | | | | | | 245 Wassacker College | | | | |
| Records, | | | $\Box a$ | 518 | | | | an autopsy ormed? | 91 | rere autopsy findings relieble prior to empletion of cause | | | | |
| Rec | | | | | | | | | | | | of | deeth? N.A. | |
| Division of Vital I | | | OF Man one referred to modical | | | | | | | | Yes 2 | 0 1 | ☐ Yes 2☐ No | |
| | | | | | | | | | | | | 4.1 | | |
| | | | To inpatient 2 Envouipatient 3D DOA 4 Anursing Home 5D Hesidence | | | | | | | | | | ry) | |
| | | Certification: | 1 Accident 5 ☐ Pending investigatio | | Day Year) Injury Work? M 1 Yes 2 No | | | | | | | | | |
| | r Atte | tific | 3 ☐ Suicide 6 ☐ Could not be determined | ry - At hom | | | | | | ocation (Streat end Number or Rural Routa Number, City or Town, Stata) | | | | |
| | To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral | Cer | 4 ☐ Homicide building, etc. (Specify) | | | | | | | | | | | |
| | | edical | (Check only Medical Exar | ysician: To the best of pinary On the basis of | f my knowle examination | edge, death | occurred et th | e time, dete | end place, eath occurr | and due to the | cause(s) and | menner as | stated. to the cause(s) | |
| | | Med | (Check only one) Medical Examplear. On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(s) and manner stated. 29b. Signature and title of cartifier 29d. Date signed (Month, Dev. Yaar) | | | | | | | | | | | |
| | | | 296. Signature and title of certifier 296. License number 296. License number 296. License number 297. License number 297. License number | | | | | | | | 77 | | | |
| | 8 | | Jun June June Dott / Dut // | | | | | | | | | | | |
| | 8 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22650 Peabody Street, P.O. Box 306, Leonardtown, Maryland 20650-0306 | | | | | | | | | | | |
| | Sta | te | 31. Date filed (Month, Day, Year) | | | | | шки 200. | wu | , | | | | |
| | Registr | 10.0 | V nin 14 | 1997 ► Jul | in aller | den-N | well | | | | | | | |



State of Maryland / Department of Health and Mental Hygiene 97 27055

| | | | | | | | | | Certi | ficate | of I | Death | | | Reg. No | o. | | _ / 0 0 0 |
|---|--|----------------|--|--|---------------------|-------------------------|---------------------------|-------------------------|---------------|-----------------------------|-----------------|-------------------------------|--------------------|---|--------------------|----------------------|-------------------------|--|
| | | | 1. Decedent's Nam | ne (First, Middle | , Last) | | | | | | | | | 2. Date of De | ath | | Vere | 3. Time of Death |
| | Physic | | Ambrose | John | Kı | cochm | alic | k | | | | | | Month August | 16 | | 997 | 4:35P.M |
| | /Med Exami | | 4a. Facility Name (| (If not institution | , give str | eet end ni | umber) | | | | 4 | 4b. City, To | wn, or L | ocation of Deat | | | of Death | |
| | ~Autili | 1161 | St. Mary' | s Hospi | tal | | | | | | 1. | eonar | dro | ωn | | | dary' | |
| - | Francis | _ | 5. Social Security I | | 6. Sex | - | 7. Age (| (In yrs. last bi | rthday) | f Under 1 | | | | | | | - | |
| | Funeral Director | | 041-05-00 Usual Residence o | 53 | | 1 2□ F | 89 | | | fonths D | ays | Hours | Min. | 8. Date of Bir (Month, De January | 8,19 | 08 | Conne | place (State or Fore intry) Cticut |
| | pue * | | 10a. State | 10b. County | | | 1 | Oc. City, Tow | n or Locat | ion | | | | | | | | 10d. Inside City Limi |
| | th the Marylens r 28a-f show | 0 | M 1 3 | Cr. M. | 1 | | ١, | | | | | | | | | | | 1 ■ Yes 2 □ N |
| | the the | Director | Mary Land 10e. Street and Nu | St. Mary | y's | | | Leonardt | | 10f. Zip Co | vde | | | | 10a Ci | tizon of | What Cou | intor? |
| | with a s | | | | _ Да /. | 22 | | | | | | ` | | | | | | |
| | eath F 23 | Funeral | Cedar Lane 11. Maritai Status | Aparuneni | | | cedent Eve | or in H C | 12 14/04 | | 650 | | h2 (C- | anife Van as No | | | Stat | can Indian, |
| | Her d | S | | rled 2 Marri | | Armed F | orces? | | If Ya | as, specify | Cuba | in, Mexican | , Puerto | ecify Yes or No Rican, atc.) | , | | ck, White | |
| 020 | within 72 hours efter death with the Maryland ane, "netural", or items 23e or 28s-f show then "netural" or items 23e or 28s-f show the Medical Examiner must be notified at | by | 3 Widowed | | 90 | If Yes, G Year or I | 2 🗆 No live Dates: | WW11 | 10 | Yes 2 | No | Specify: | | | | Specif | v: Whi | te |
| 5-0 | 72 h | Completed | (Spe | 15. Decedent' | s Educat | ion om <i>pleted</i> | 1 | 16a | Decedent | t's Usuai C | ocupi | ation | of work | rina | 16b. K | (ind of B | usiness/Ir | ndustry |
| 21 | ig | ğ | Elementary/Seco | | grade o | | (1-4or 5+) | | life. DO | NOT use r | etired | during most | OI WOIN | ang . | | | | |
| 2 | e filed within el Hygiene. other than | S | 12 | | | | | | Super | viso | r | | | | Tex | tile | e Ind | lustry |
| pu | M T T T T T T T T T T T T T T T T T T T | Be | 17. Fathar's Name | | , | | | | | | | 18. Mothe | r's Nam | e (First, Middle | , Meider | Sumen | ne) | |
| <u>e</u> | should be nd Mentel merked or | 0 | John I. | Krochma | lick | ζ | | | | | | Wic | tor | ia Kost | yra | | | |
| Maryland 21215-0020 | | ľ | 19a. Informant's N Stephen A. | | | | | 7.5 | _ | | | | | ral Route Numb | | | | |
| Baltimore, | is 1 and 2 of Health itam 27 is other tre | | 20a. Method of Dis | position | | | | 20b. Place o | f Disposition | on (Neme | of | | | Date | 20c. L | ocation | City or T | own, State |
| J OH | permit. Peges Depertment of i Important: If ite any injury or or once. | | | Cramation | | ovai from | State | | ry, cremate | | r plec | 00) | 0 | -21–1997 | Dudi | ou 1 | danna | busatta |
| 喜 | orthur mojur | | 21. Significant | 5 Other (Sp | | 0 | | Calvary | | | olel on a | a of Easille | 1 | | | | | chusetts |
| Ba | pemit. Depertr Importu any inje | | Toler | 11/16 | 21/ | 1 |) | | 22.19 | ame and A | vooras | ss of Facility | Brin | sfield F | unera | 1 Hor | ne, P. | Α. |
| _ | | | | N. Brins | - | | M000 | | 2295 | 5 Holl | ywo | od Road | i, Le | conardtow | n, Ma | ryla | nd 206 | 50-0279 |
| | | | 23a. Part1. Enter t shock, or hea | the disaasa, or our tallet failure. List o | complicationly one | cause on | caused the eech line. | e daath. Do | not antar t | ha moda o | f dyin | g, such as | cardiac | or raspiratory a | rrest, | | | Approximate Interval Between |
| | Physician /Medical | | Immediate Cause | (Final | | Pr | (. | pnec | ه دهد ا | ou | 9 | | | | | | | Onset and Death |
| | Examiner | | disease or condition resulting in death) | on | a | | • | | | | | | | | | | i | |
| | | ē | | | | ~1. | | e to (or as a | | | | | ۸. | | | | 1 | |
| | uted d ansit | Examiner | Convenient the Vet | | b | 101 | 1 | o H 6 | | 1 | > | , | *11 | 1 e mos | ٦. | | | |
| Ć. | execun an an iel-tr | EX | Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that Initiated event) | nmediate | | 9 | CA | VIII WALLES | consequen | • | FIL | _ | | | | | | |
| 76(| e be sicla e bui | edical | Cause (Disease or that initiated events | Injury | c | _ | | e to (or as a | onegguen | 1 | 1-1 | 0 | | | | | | |
| 68760, | that the death certificete be executed ed by the attending physician and detached for use as the buriet-transit | g | resulting In deeth) | Last | | | Du | e to (or as a t | onsequen | ce on: | | | | | | | | |
| × | ndin use | M | | | d | | | | | | | | | | | | | |
| IC B | atte 3 for | cia | Darill Other sleet | Nanatana diala | | | 1 | | | | | | | | | | | |
| MALICK P.O. Bo | that the death led by the atter | Physician | Part II. Other signif | iicanii condilior | 10 CONTRE | uting to a | eath out n | not resulting if | the unde | nying caus | a give | en in Part I. | | | | | | o the cause of deat |
| 图中 | that thed b | | | | | | | | | | | | | 10 | Yee 2 | !∐ No | 3 Pro | bebly 40 Unkno |
| AMBROSE JOHN KROCHMALICK Division of Vital Records, P.O. Bo | w requires that been signed b should be det | d by | | | | | | | | | | | | 24a. Was | en auto | n n | 24h W | ere autopsy findings |
| N P | peed | ete | | | | | | | | | | | | perfo | rmed? | hay | av | vailable prior to empletion of cause |
| S S | hes t | Completed | | | | | | | | | | | | | | | | death? |
| JOHN tal Re | ician: The lev certificate hes rector, page 2 | ပိ | | | | | | | | | | | | 10 | Yes 2 | ■ No | 11 | Yes 2 No |
| /its | Physician: this certific rral director, | Be | 25. Was casa refer | red to medical | | | | | | | | | of Deat | h (Check only o | one) | | | |
| SE | Physic this or ral dire | 2 | 1 □ Yes 210 | No | Hos | pital: 1/X | Inpatient | 2□ ER/Ou | tpetient : | 3□ DOA | Othe | er: 4□ Nur | sing Ho | me 5 Resi | dence | 6 Oth | er (Speci | fy) |
| n o | fer the | | 27. Manner of Deat | h 5 🗌 Pending | | 28a. Date (Mon | of Injury | | Time of njury | 28c. | injury Work | at s? | | 28d. Describe | how inju | ry occur | red | |
| AMBROSE sion of V | Attending ir death. ector: After by the fune | ati | 2 ☐ Accident | investiga | ation | | | | | М | | Yes 2□N | lo | | | | | |
| N N | for Attending lefter death. Director: After d in by the fune | Certification: | 3 ☐ Suicide 4 ☐ Homicide | 6 Could no determin | ned a | 28e. Place build | of Injury ing, etc. (5 | - At home, fa | rm, street, | factory, of | fice | | | 28f. Location (| | | er or Run | al Route Number, |
| | rs eff | Ç | | | | | | ,, | | | | | | | | | | |
| | To the Hospital or Attending Physician: The lew within 24 hours effer death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | edicai | 29a. Certifier (Check only one) | 1 Certifying 2 Medical E | Phyalci xaminer: | : Un the b | best of m | amination an | , death oc | curred et ti igation, in | ne tim my op | ne, date end olnion, deati | place, h occurr | end due to the red at the time, | cause(s dete en |) end me d place, | enner as s and due t | stated. o the cause(s) |
| | Fo the | Me | 29b. Signatura and | titie of cartifiar | | | | - | | 29c. LI | cansa | number | | | 29d. Da | ta signe | d (Month. | Dey, Year) |
| | F 3 F 8 | | | ASU | al | 1 2 | | | | D | 4 | 1706 | 6 | | < | | 819 | |
| | | | 20 November 1 | | | | | | | | | | | | | | - ' ' | 1 |
| | | | 30. Name and addre | ess of person w | | | se of deat | h (Item 23a) (LEONA | | | .20 | 0650 | | | | | | |
| | Sta | ite | 31. Data filed (Mon | th, Dey, Year) | 1007 | 32. F | egistrar's | Signature | 2 | | - | | | | | | | |
| 7 | Registr | ar | | 100 10 | וטטו | 19 | the do | wolson | ardall. | | | | | | | | | |

DHMH 16 Rev 6/95

Piease Type or Print in Biack indeiibie Ink. Assure Ali Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month 4b. City, Town, or Location of Death Joseph Kemp Benoni 1997 2320 4a. Facility Neme (If not institution, give street end number) 4c. County of Death Medical Center Annapolis If Under 1 Year If Under 2 Hrs. 8. p. Anne Arunde Arundel 5. Social Security Number Birthplaca (Stata or Foreign Country) 7. Age (In yrs. last birthdey) 6 Sex 10XM 201 F Months Hours Yrs. 13 July 29, 1997 Maryland Usuel Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland St. Mary's Mechanicsville 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 40605 Bishop Road 20659 United States 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ■ No if Yes, Give Yaar or Dates: 11 Maritai Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Biack, Whita, etc. 1 ■ Never Merried 2 ☐ Merried 1 ☐ Yes 2 ■ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda complated) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Charles T. Kemp Mary E. Mayotte 19e. Intorment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles T. Kemp, Father 40605 Bishop Road, Mechanicsville, Maryland 20659 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ■ Buriel 2 □ Crametion 3 □ Removel from Stete Charles Memorial Gardens 8/13/97 Leonardtown, Maryland 4 Donetion 5 Other (Specify)

21. Signature of Shoral Source (Specify) 22. Nama and Address of Facility MUST Brinsfield Funeral Home, P.A. Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death tmmediate Ceuse (Finei Heart Defeat disease or condition resulting in death) laison Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Due to (or es a consequence ot): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to 24e. Wes en eutopsy performed? complation of causa of death? 1 Yes 2 No AZ No 25. Was case referred to medical exeminer?

1 Yes No 28. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospitel: Linpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28c. tnjury at Work? 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 5 Panding investigation Neturel

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

þ

Completed

Funeral

Director

item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

filed within 72 hours after Hygiene.

permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any Injury or other traumatic auctor.

Baltimore, Maryland 21215-0020

deeth with the Manyland

Examiner Physician/Medical þ Completed Be 2

physician and the burial-transit Certification:

The lew requires that the death certificate be executed 3 signed t page 2 should peen : this certificate has To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director, I

Division of Vital Records, P.O. Box 68760,

Suzanne 31. Dete tlied (Month, Dey, Year) State Registrar

2 Accident 3 Suicide

4 T Homicide

29b. Signeture end title of cartitier

29e. Certifier

Medical

6 Could not be

Desse 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rindtleisch

28a. Plece of Injury - At home, ferm, street, tactory, office building, etc. (Specify)

29c. License number 442733

No Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and mannar stated.

29d. Dete signed (Month, Day, Year) August 11, 1997

28f. Location (Street end Number or Rural Routa Number, City or Town, Stete)

2001 Medical Pkwy

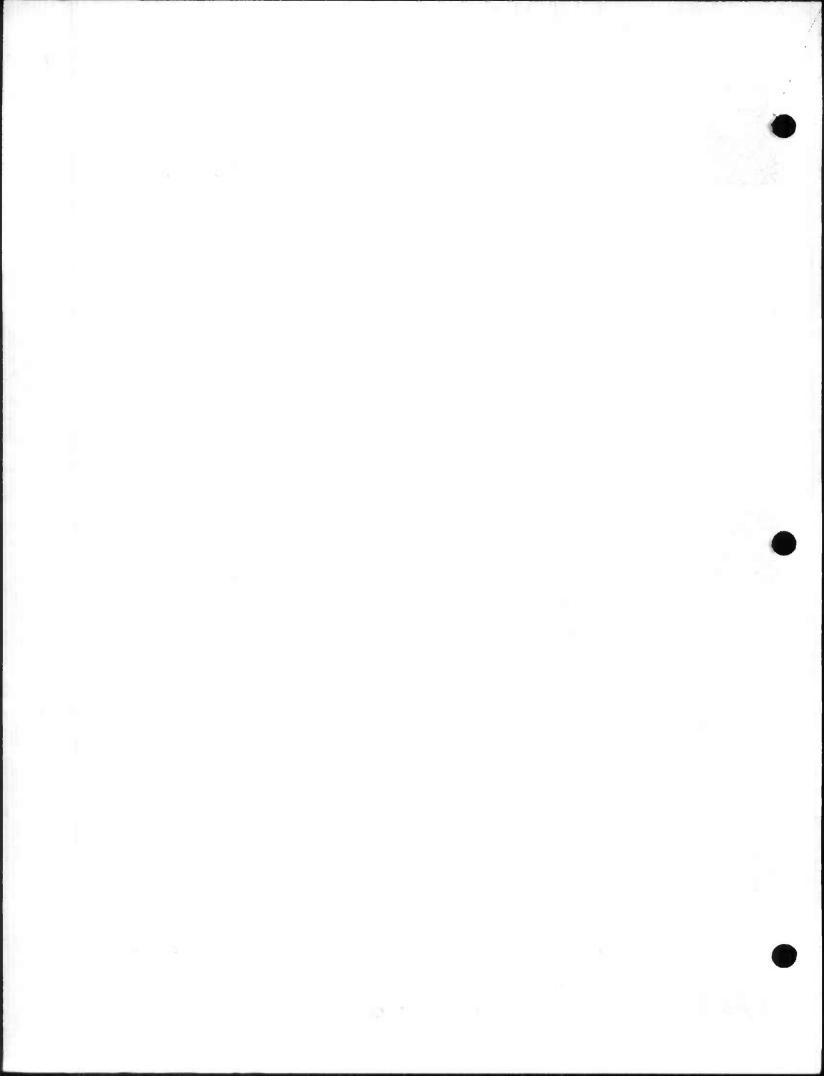
1 Yes 2 No

Anapolis mo 21410

32 Registrer's Signeture Talk Davelen Randall AUG 22 1997

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 27057

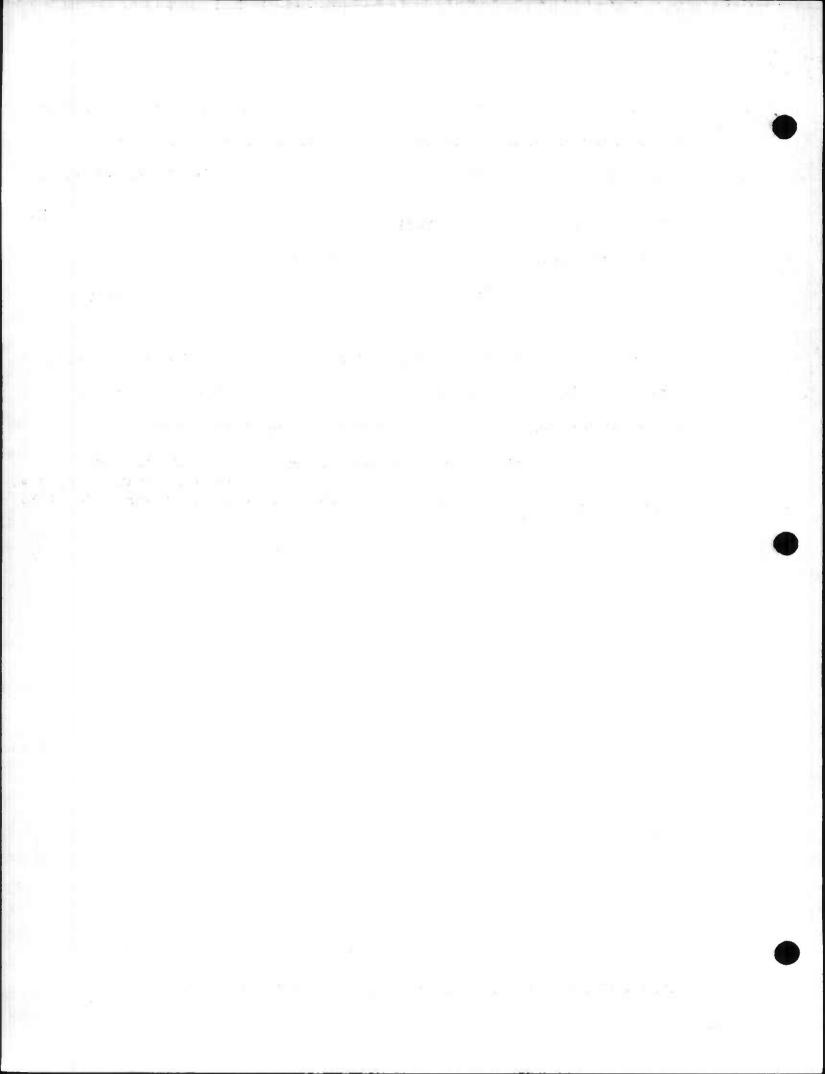
| | | | | | ,, | Cer | tificate of | | | Reg. No. | [Com] | 1001 |
|---------------------|--|-------------------|--|--|---------------------------|-------------------|---------------------------------------|--|--|-------------------------------|--|-----------------------------------|
| | Dharia | | 1. Decedant's Name (First, Middle, | | | | | | 2. Data of De | ath | | 3. Tima of Death |
| | Physic /Medi | | Virgie Ma | ae Kiniu | k | | | | Aug. | 26, Day 199 | 7 | 1417 |
| h | Exami | | 4a. Facility Nama (If not institution, g | | | | | 4b. City, Town, or Lo | | h 4c. County | of Death | |
| | | Ш | Atlantic Ger | | | | 141- | Berl | in | Wor | cceste | |
| | Funeral Director | | 212-16-1940 | Sex 7. Ag | a (In yrs. last bli 78 | rthday) Yrs. | if Under 1 Yaa Months Days | | 8. Date of Bir (Month, Da Aug. 2 | 4, 1919 | 9. Birthplace Country Mary | ce (State or Foreign yland |
| | and * | | Usual Residence of Decedent 10a. State 10b. County | | 10c, City, Tow | n or Loc | cation | | | | 104 | . Inside City Limits |
| | Sef sho | etor | Maryland Doro | chester | | | mbridg | е | | | | 14 Yes 2□No |
| | 23a or 2 | Funeral Director | 10e. Street and Number 218 Rambler I | Road | | | 10f. Zip Coda 21 | 613 | | 10g. Citizan of V | What Country | 7 |
| Maryland 21215-0020 | i within 72 hours after death with the Maryland ilene. Than "natural", or flerms 23a or 28a-f ahow the Medical Examinet must be notified at | by | 11. Marital Status 1 □ Never Married 2 □ Married 3 ሺ Widowed 4 □ Divorced | 12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates: | | | Vas Decedant of Yas, specify Cu | Hispanic Origin? (Sp ban, Maxican, Puarto Specify: | ecify Yas or No Rican, atc.) | 14. Rac Blac Specify | ce - American ck, Whita, ato y: Whi | |
| 5-0 | 72 ho | Completed | 15. Decedant's (Specify only highest of | Education | 18a. | . Deced | lant's Usual Occi | upation | ina | 16b. Kind of B | usiness/Indus | stry |
| 21 | within ene. | nple | Elementary/Secondary (0-12) | College (1-4or | 5+) | | NOT use retir | e during most of work ed) | | Dog | h = | |
| 2 | | | | -41 | | | waltre | | | | taura | ΠE |
| and | d la d | Be | 17. Father's Name (First, Middle, La William Hen) | | on | | | 18. Mother's Nam | | Schuyl | | |
| Z | d 2 should th and Men 7 is merke traumetic | To | 19a. Informant's Name/Relationship | | | . Mailin | n Address (Stree | et and Number or Run | | | | odeb 1 0 6 0 |
| Ĭ | 47 5 67 | | Lois S. Ebers | | | | | | | | | |
| ore, | T S S S | | 20a. Method of Disposition | | 20b. Place o | f Dispos | sition (Name of natory or other pl | ace) | Date | 20c. Location - | City or Town | ı, State |
| m | Pages nent of I int: If Its iry or of | | 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Special Control Cont | | (| | | Ukr. Cem. | 9-2 | Helle | ertown | n, PA |
| Baltimore, | permit. Page Department of Important: If any Injury or once. | | 21. Signature of Funeral Service Lio | ensee 0 | | | | ress of Facility Bromwell | | | | |
| œ | 88168 | | Carron Arss | N-HOW | 11400 | | | St., Ca | | | 21613 | |
| | | | 23a Part1 Enter the disease, or co shook, or heart failure. List on | mplications that caused y one cause on each li | the death. Do- | | | | | | A | pproximate iterval Batween |
| | Physician | 1 | | | | -1 | | | | | 0 | Inset and Death |
| | /Medical Examiner | | Immediate Cause (Final disaasa or condition resulting in death) | a. Colono | my ar | ten | 1 disco | ase, | | | me | nyke |
| | | - G | | | Dua to (or as a | | | | | | 1 | |
| | uted d ansit | Examiner | Consumation that the state of t | b | Due to (or as a | 0000000 | uence of): | | | | - i | |
| oʻ | rificate be executed ng physician and as the burial-transit | Exa | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury | | Due to (or as a | consequ | uarice or). | | | | | |
| 68760, | ite be iysicia he bu | Cal | Cause (Disease or Injury that Initiated avants resulting in death) Last | C | Due to (or as a | consequ | uanca of): | | | | | |
| | # P# | /Wed | lesulting in death) cast | d | | | | | | | <u> </u> | |
| O. Box | atte | Physician/Medical | Part II. Other eignificant conditions | contributing to death b | ut not resulting in | n the un | nderlying cause g | ivan in Part I. | 23b. Dld | tobacco uee co | ntribute to th | ne cause of death? |
| P.0 | requires that the de been signed by the should be deteched | | | COPD | | | | | 10 | Yee 2□No | 3 Probet | bly 48 Unknown |
| Records, | uires sign id be | d by | | | | | | | 24a Was | an autopsy | 24b. Were | autopsy findings |
| Ö | beer shou | Completed | | | | | | | | omed? | avalle | able prior to eletion of cause |
| Re | The law ate has b page 2 s | duic | | | | | | | 10 | Yes 2 No | | /es 2□ No |
| Viita | | BeC | 25. Was case referred to madical | | | | | 26. Place of Deat | | | 101 | 63 20 140 |
| > | 0 0 | To B | examiner? | Hospital: | nt 2□ER/Ou | utpatient | 3□ DOA O | ther _ | | dence 6 □Oth | er (Specify) | |
| on of | Attending Physic death. ector: After this by the funeral di | | 27. Manner of Death 1.☑Natural 5 ☐ Panding 2 ☐ Accident investigat | 28a. Date of Inju (Month, Da | ry Year) 28b. 1 | Time of Injury | 28c. Inju W | ury at ork? | 28d. Describe | how Injury occur | red | |
| Division | 2 4 4 E | Certification: | 3 Suicida 6 Could not determine | 28e. Place of Inj building, etc. | ury - At home, fa | ırm, stre | et, factory, office | | 28f. Location (. City or To | Street and Numb wn, Stata) | per or Rural R | louta Number, |
| | To the Hospital within 24 hours e To the Funeral C completely filled | edical C | 29a. Certifier (Check only 2 Madical Fx | Physician: To the best of aminer: On the basis of | of my knowledge | e, death | occurred at the t | time, date and place, | and due to the | cause(s) and ma | anner es state | Rd. |
| | the H the F the F | Ped | one) | and manner ste | ated. | WOI IIIV | | | od at the time, | | | |
| | To vite to the second of the | Σ | 29b. Signatura and titla of certifiar | | | | | nse number | | 29d. Data signe | | y, Year) |
| | | | Church | omo | | | Doo | 50605 | | Aug: | 26 97 | |
| | | | 30. Nama and addrass of person who | | eath (Itam 23a) | (Type, F | Print) 973 | 3 Health | vay or | , | | |
| | - 54- | to | | | ar's Sjonature | | BI | shi MD | 218 | // | | |
| | Sta Registr | - | AUG 2 | 9 1997 Jak | dructes | Ren | dall | | | | | |



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Daath 3. Time of Death Month **Physician** ETHEL 23, 1997 9:20 AM LOUISE NIBLETT AUG. /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SALISBURY Center: Genesis ElderCare Salisbury, Md. Wicomico If Under 1 Year Months Days If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) **Funerai** Months Hours Min. 1 □ M 2 🕱 F Director 12 14 26 218-20-2716 Salisbury, MD Usuel Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show traumetic event, the Madical Examinar must be notified at 1 ☐ Yes 2 Ki Ko Director WICOMICO SALISBURY 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 242 Mildale Drive 21801 12. Was Decedent Ever In U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amaricen Indian, Black, White, etc. 11. Marital Status permit. Peges 1 and 2 around be filed within 72 hours after begarment of Health and Mantal Hygiena. Important: if item 27 is marked other than "naturel", or ite any highry or other traumatic event, the Mactical Examination 1 ☐ Yes 🏋 🖾 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify:WHITE ρΛ 3 ₩ Widowed 4 Divorced Year or Dates: 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Womans Clothing Sales Clerk 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) 2 James Whayland Betty Mae 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Rick A. Niblett-Son 413 Midland Terrace,, Salisbury, MD 21804 20b. Pleca of Disposition (Name of cemetery, cremetory or other placa) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Entombment Wicomico Memorial Park 8/26/97 Salisbury, MD 22. Name and Address of Facility HOLLOWAY FUNERAL HOME, P.A 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrast, shock, or heart feliure. List only one couse on each line. 501 Snow Hill Road, Salisbury, 21804 MD Approximata Interval Between Onsat and Death Physician /Medical Immediate Cause (Final disaase or condition rasulting in death) . Complications Gen 28 Examiner Due to (or as a consequence (i) Examiner attanding physician and for use as the burial-transit Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): certificate be execu Box 68760. Physician/Medicai Due to (or as a consequence of): resulting In death) Last P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 100 1 Yee 2 No 3 Probably 4 Unknown signed by Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of ceusa of death? 24a. Was an eutopsy Completed performad' certificate has 1□ Yes 2 No 1 ☐ Yes 2 No funeral director, 25. Was case refarred to medical Be 26. Plece of Death (Check only one) axaminer? 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) 2 After this 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred s after death.
It Director: After so in by the funer 1 Neturel 2 Accident 5 Pending investigation Injury 1 Yes 2 No 3 ☐ Suicide 6 Could not be 28e. Placa of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) end menner stated. ledicai 29a. Certifier (Check only one) To the P within 2. 29b. Signatura and title of contilion 29c. Licansa number 29d. Dala signed (Month, Day, Year) D-39813 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL ATKINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD. 21804 31. Date tiled (Month, Day, Year) July Davidson hardell State AUG 261997

Registrar



State of Maryland / Department of Health and Mental Hygiene 97 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death

Physician /Medical Examiner

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ELWOOD

July 30,1997 LAMBERT

11:55a.m.

Funerai

Director

Director

Funeral

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Completed

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death with the Maryland itam 27 is marked other than "naturel", or itema 23a or 28a-f show other traumatic event, the Magical Examiner must be notified at permit. Pages 1 and 2 should be filed within 72 hours aftar c Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "naturel", or ther any injury or other traumetic event, the Medical Evantant

Saltimore, Maryland 21215-0020

Box 68760.

P.O.

Records,

Division of Vital

Physician /Medical Examiner

burial-transit and physician sthe burial usa signed by the a d be datached f peen carlificata Hospital or Attending Physicien: 24 hours after death. Funeral Director: After this certifice funaral

Physician/Medicai ò Completed Be ⁰L Certification: n 24 hours af the Funeral Di plataly filled in Medicai To the Vithin 2

4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Calvert Memorial Hospital Prince Frederick Calvert 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 1**⊠** M 2□ F Hours 213-82-1236 Yrs. 38 Mar 31, 1959 Maryland Usual Residence of Deceden 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4189 Log Teal Drive 20603 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1☑ Never Married 2☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Yes 2 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Special Education Teacher Public Schools vears 17. Father's Name (First, Middle, Lest) 18. Mother's Neme (First, Middle, Meiden Sumame) Lambert Marvin El wood Margaret Frances Fauber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addreas (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Margaret F. Lambert/Mother P.O. Box 73, Wachapreague, VA 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wachapreague Cemetery 8/2/97 Wachapreague, VA 21. Signature of Funeral Service Licens 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. the the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, heert feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Onevmonia 2 weeks disease or condition resulting in death) Due to (or as e consequence of) AIDS Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last Due to (or as a consequence of): Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Cylangelouvus in fection 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? MAC infaction 2 0 No 1 ☐ Yea 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 12 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No

27. Menner of Death 1 Neturel 2 Accident 3 Sulcide 4 | Homicide

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Dev Year)

28b. Time of 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

28d. Describe how Injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a, Certifier (Check only one) 15 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number B38991 29d. Dete signed (Month, Dey, Year) July 31, 1997

30. Neme and eddress of person who completed ceuse of death (Item 23e) (Type, Print)

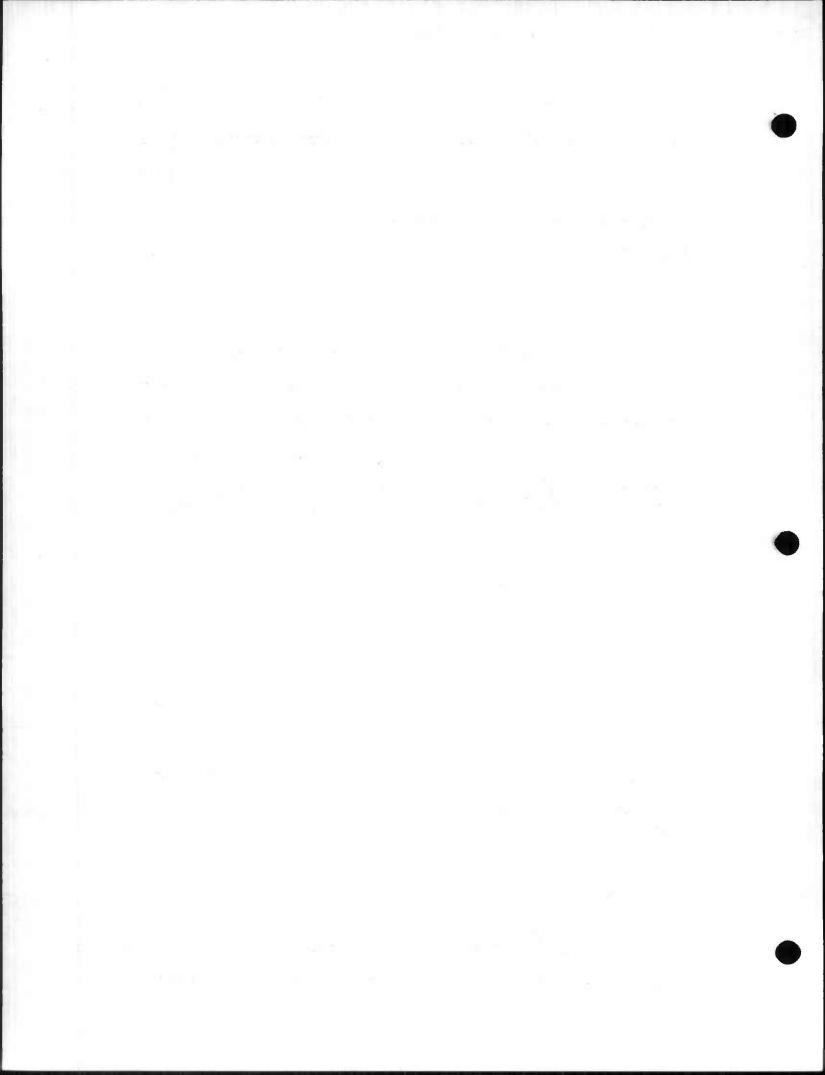
Prince Frederick, MD. 20678 Dr. Michael D. Dipre, M.D.

State Registrar



MA

B



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Deeth **Physician** Month William August 24, 1997 Franklin Lewis 2:05 PM /Medical 4b. City, Town, or Location of Deeth 4e. Fecliity Neme (If not Institution, give street end number) 4c. County of Death Examiner Waterview Health Care Center Salisbury Wicomico 5. Sociel Security Number If Under 1 Yeer | If Under 24 Hrs. | Months | Deys | Hours | Min. | 8. Dete of Birth (Month, Dey, Year) 03/24/1905 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Director Yrs. 215-01-0130 92 Maryland Usuel Residence of Decedent permit. Peges 1 and 2 should be filled within 72 hours efter death with the Maryland Department of Heelth and Mentel Hygiene.

Important: If item 27 is marked other than "natural". or Managements in the mary injury or other traumatic event 10e Stete 10h Count 10c. City, Town or Location 10d. inside City Limits 12 Yes 2 □ No Director Maryland Wicomico Salisbury 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 105 Times Square 21801 U.S. Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Yeer or Detes: 14. Rece - American Indien, Bieck, White, etc. 11. Meritel Stetus Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 No Specify: by Specify: 3 ☐ Widowed 4 € Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Truck Body Builder Transportation 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) John Franklin Lewis Edna Waller 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Meredith/ Friend Box 142, Upper Fairmount, Md. 21867 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Bunel 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) All Saints Monie Cem. 8/27/97 Venton, Md. 21. Signature of Funeral Service Ligensee 22. Neme end Address of Facility Hinman Funeral Home Part1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Princess Anne, Md. 21853 Congretive Heart Failure.

Due to (or as e consequence of):

Grastopintes final Bleeding immediate Cause (Fine) disease or condition resulting in deeth) Examiner Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Dementia Physician/Medical Due to (or es e consequence of) Pert il. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 □ Probably 4 ☑ Unknown ρV Completed 24e. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical 28. Piece of Deeth (Check only one) exeminer?
1 ☐ Yes 2 ☑ No Hospitei: 1 Inpatient 2 ER/Outpatlent 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident 8 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide edical 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner as stated.

2 Madicat Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29e. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) Thomas V. Joseph 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

ST , SUITE 504B, SALISBURY. MD 21804

State Registrar 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture AUG27

MILFORD

Physician

/Medical

Examiner

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page 2

filled in by the funeral

certificate

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After

within 24 hours after death.

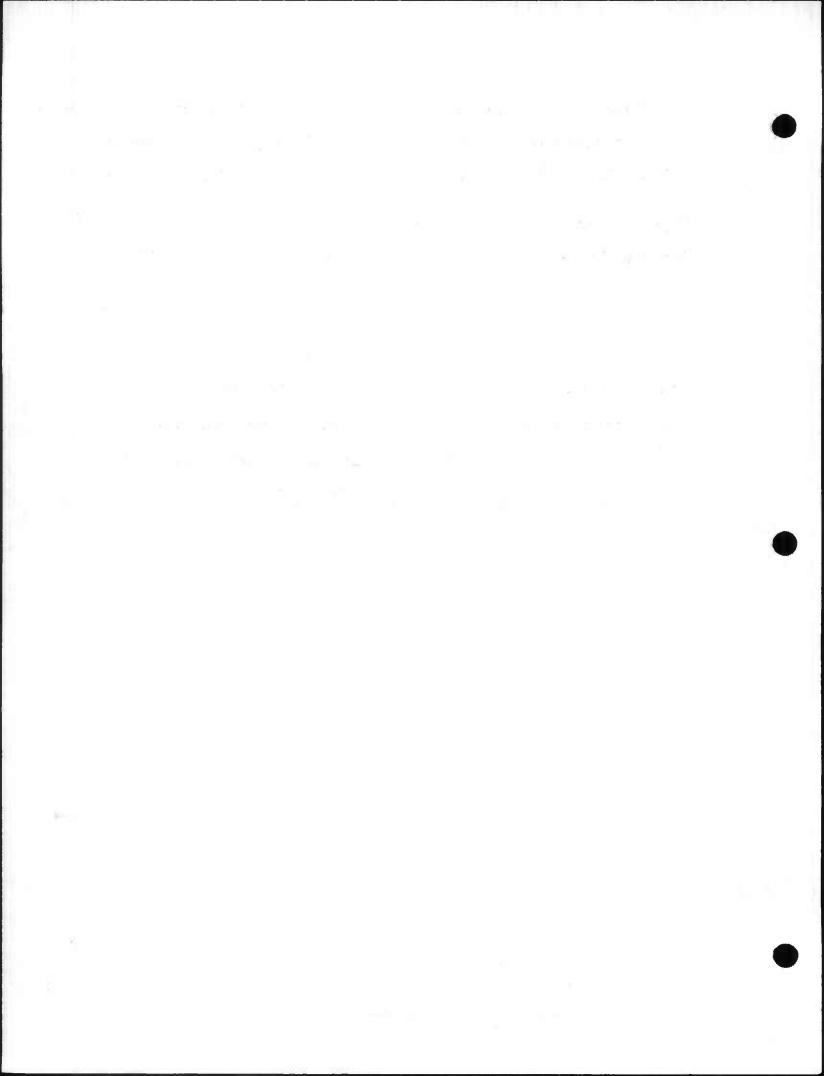
To the Funeral Director: A completely filled in by the fu

To the

Hospital or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records.

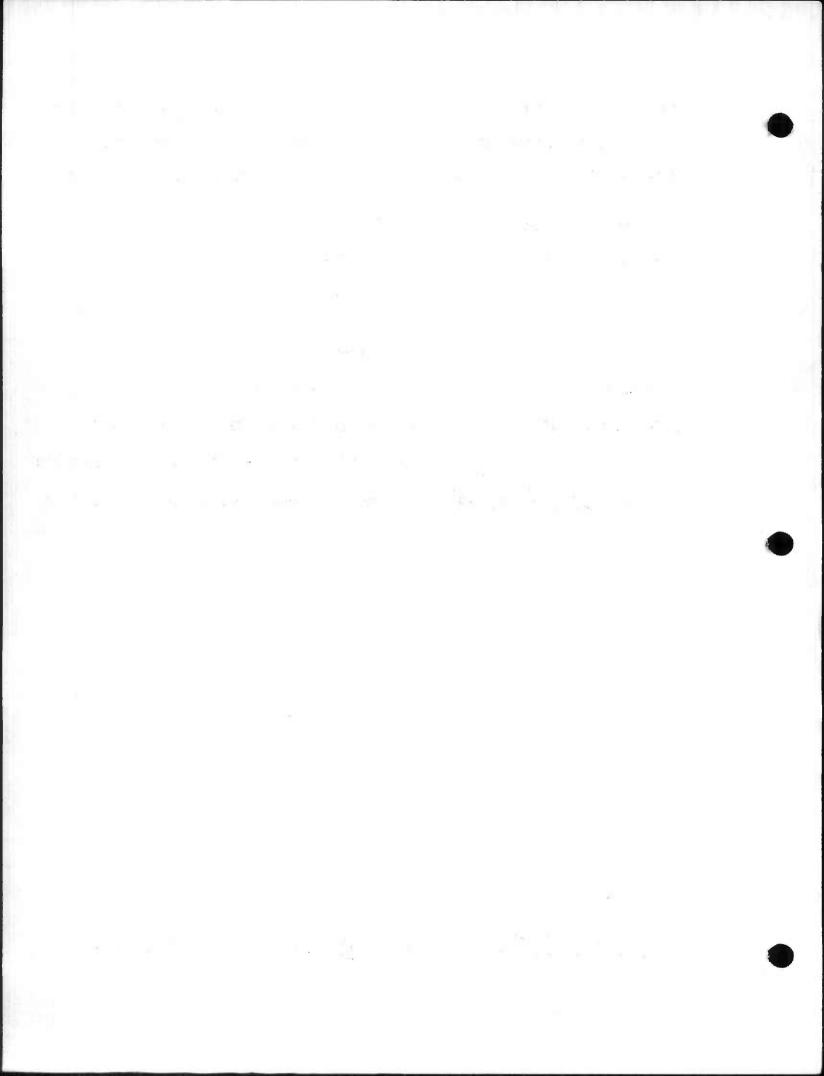


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0.7

| | | | | State of Ma | aryiani | | | | Death | mentai n y | Reg. No. | 1 2 | 1061 |
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| | | U. | 1. Decedant's Nama (First, Middla, La | ist) | | | | | | 2. Data of De | eath | | 3. Tima of Death |
| | Physici | | EDWARD | LEE | | MO | RRIS | | SR | Month O8 | 23 | Yaar 97 | 0650 |
| 2 | /Media Examir | | 4a. Facility Nama (If not Institution, gir | | | 110 | TULLO | | 4b. Clty, Town, or | | | | 0630 |
| 71 | LAGIIII | 161 | 29315 NAYLOR MILL | ROAD | | | | | SALISBU | ov | WICOM | | |
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| s.V | Director | 1 | 219-36-6138 Usual Rasidance of Decedant | MM OF E | 56 | Yrs. | Month | s Days | Hours Min. | (Month, Di | | Mary | ce (Stata or Foreign Land |
| | anyland show | _ | 10a. Stata 10b. County | | | , Town or | | | | | | 10 | d. Insida City Limits |
| | Page 1 | Director | Maryland Wicon | nico | 5 | Sali | sbur | У | | | | | 1 Yas 2 No |
| | or 2 | Dire. | 10e. Street and Number | | | | | ZIp Coda | | | 10g. Citizen of V | | y? |
| | 23a | | 29315 Naylor | Mill Road | 1 | | | 2180 | 1 | | U.S | . A | |
| Maryland 21215-0020 | d within 72 hours effer death with the Maryland Jene. r than "natural", or items 23a or 28a-f show the Madgal Examiner must be notified at | by Funeral | 11. Marital Status 1 Navar Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedant Armed Forces? 1 Yas 2 1 If Yas, Giva Yaar or Datas: | Evar In U,S No | S. 13 | | pedant of Poecify Cuba | fispanic Origin? (S an, Maxican, Puar Specify: | Specify Yas or No to Rican, atc.) | Specify | e - Amarica ck, Whita, and c: BLA | ic. |
| 2-0 | 72 hc | ted | 15. Decedant's E | ducetion | | 16a. Dec | edant's Us | sual Occup | pation | ede las es | 16b. Kind of B | | |
| 21 | G 9 | Completed | (Specify only highast gro Elamantary/Secondary (0-12) | Collega (1-4or 5 | (4) | lita | DO NOT | usa retire | during most of wo d) | rking | | | |
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| pu | be filed ital Hygi d other event, t | Be | 17. Fathar's Nama (First, Middla, Last |) | | | | | 18. Mothar's Na | ma (First, Middle | , Ma <i>ide</i> n Sumam | ia) | |
| <u>a</u> | should b nd Menta marked imatic e | TOE | Warner Morris | | | | | | Paulin | e Ryde | r | | |
| any | | | 19a. Informant's Name/Ralationship | Type, Print) | | 19b. Ma | iling Addra | ss (Street | and Number or R | ural Routa Numb | er, City or Town, | Stata, Zip C | Code) |
| | 75.5 | | Edward Lee Mor | ris JR.(S | Son) | 12 | Sunn | yvie | w Rd.Re | hobeth | , DE 19 | 971 | |
| altimore, | ages 1 and nt of Heelth of Other 27 | | 20a. Mathod of DIsposition | | 20b. Pl | ace of Dis | position (A | lama of | | Data | 20c. Location - | | m, Stata |
| 90 | Pages nent of I mrt: If Its iry or o | | 1 Buriai 2 □ Cramation 3 □ 4 □ Donation 5 □ Othar (Special | | | | amatory of | | ce) | 8/18 | Salis | huru | БМ |
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| Ba | permit. Page Department of Important: If any injury or 90058. | | Hladys B. | Stewart | | | Stew | art | Funeral Rd.Sal | | Md 21 | 801 | |
| | | | 23a. Part1. Entar tha diseasa, or com shock, or haert failura. List only | plications that ceused | tha daath | . Do not a | intar tha m | oda of dylr | ng, such as cerdia | c or respiratory a | arrast, | | Approximata nterval Between |
| 41 | Physician | | | | | | | | | | | | Onset and Death |
| 4 | /Medical | | Immediata Causa (Final disaasa or condition | ARTERIOS | CLERO | OTIC (| CARDT | OVASO | TITAR DIS | SEASE | | | |
| н | Examiner | | rasulting In daath) | a | J. Link D. St. and St. St. | UVVIUI | equance o | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | 1 | |
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| | icate be executed physician and s the burial-transit | Examiner | Sequentially list conditions, if any, laading to immadiata | b | Dua to (or | es a cons | equance o | f): | | | | | |
| oʻ | an a | m | cause. Entar Undarlying | | | | | | | | | į | |
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| Вох | death certifi e ettending ad for use as | 2 | | d | | | | | | | | i | |
| | 0 0 0 | Physiclan/M | Part II. Other significant conditions of | ontributing to death be | ıt not rasu | Iting in tha | underlylno | ceuse giv | an In Part I. | 23b. Dld | tobacco use co | ntribute to 1 | the cause of death? |
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| 'n. | res that the ligned by the be detach | by F | | | | | | | | | | | |
| of Vital Records, | been should | Completed | | | | | | | | | s an autopsy ormed? | com | e autopsy findings lable prior to pletion of cause eath? |
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| > | Physician: this certific ral director, | ToB | axaminar? 1 □XYas 2 □ No | Hospital: | nt 2 🗆 E | -B/Outpati | ent 3 🗆 I | Oth | ar | | idance 6 Oth | or (Concibe) | |
| | Phy ir this | | 27. Mannar of Death | 28a. Data of Injur | у | 28b. Tima | | 28c. Injui | | | how Injury occur | | |
| O | ding th. After fune | 를 | 1 XNaturai 5 ☐ Pending 2 ☐ Accidant Invastigatio | (Month, Day | Year) | Injury | M | | 1k? Yas 2∐No | | | | |
| Division | or Attending effer death. Director: After in by the fune | Certification: | 3 Sulcida 6 Could not b | e one place of lair | ury - At hor | ma. farm. s | streat, facto | orv. office | | 28f. Location | Street and Numb | er or Rural | Routa Number. |
| = | or A effer Dire | E I | 4 Homicide | building, ato | . (Specify) |) | | ,, | | City or To | wn, Stata) | | • |
| | Hospital 24 hours Funeral stely filled | | 29a. Certifiar 1□ Certifying Ph | yaician: To the best of | f my know | dedne des | ath occurre | vd at the tir | na data and niace | and due to the | cauca(s) and ma | nner ec ete | ted |
| | Pur Fur etely | edicai | | niner: On the basis of end manner ste | axaminati | on and/or | Invastigation | on, In my o | pinion, daath occi | rred at tha tima, | deta and place, | and dua to t | ha ceuse(s) |
| | To the Hospital or Attending Ph within 24 hours effect death. To the Funeral Director. After th completely filled in by the funeral | Σ | 29b. Signatura and titla of certifiar | - To Thairmon Ste | | | 2 | 9c. Licans | a number | | 29d. Data signe | d (Month, D | ay, Year) |
| | MAD | | de non | | | | | | | | | | |
| 1 | reordo | - | 20 1100 00 00 00 | pulselly | | D.M.I | | D0359 | 9 | | 08-23-9 | 7 | |
| - { | 21 | - 1 | 30. Negra and addrass of person who | | | | | | | 11 | | | |
| | _ | _ | JOHN T. BULKELEY, 31. Data filed (Month, Day, Year) | M.D., 108 | PINE | BLU | F RO | AD, S | ALISBURY | MD 218 | 01 | | |
| | Sta Registra | - | AUG 26 199 | Julia ala | when ! | Kardal | 6 | | | | | | |

| | | | Plea | | | | Depa | artmen | t of H | | and M | I Coples Iental Hyg | | gible. 7 2 | 7062 |
|---------------------|--|---------------------|--|----------------------------------|---------------------------------------|---|--------------------------|--------------------------|-------------------------|---|------------|--|---------------------------------|-----------------------------|--|
| | Physic /Medi | | Decedant's Name (First, Middle ROBERT | lie, Last) MIRO | | | | | | | | 2. Date of Dea Month | Day | 97 | 3. Time of Death 0833 |
| | Exami | | 4a. Facility Name (If not institution | | | or) | | | 4 | 4b. City, To | wn, or Lo | ocation of Death | 4c. Cour | ty of Death | |
| | | | ATLANTIC GENER | | | has the same head | for Conference of | If Undar | | BERLI If Undar | | | | ESTER | |
| | Funeral Director | | 5. Social Sacurity Number 265-28-0425 Usual Residence of Decedent | 6. Sax 1 ☑ M 2 | | 72 | Yrs. | Months | Days | Hours | Min. | 8. Data of Birti (Month, Day MAR • 1 , | 1925 | 9. Birth Cou NEW | piaca (Stata or Foreign ntry) YORK |
| | be filed within 72 hours after death with the Marylend hal Hyglene. d other than "natural", or itama 23a or 28a-f ahow evant, the Mod ral Exeminer must be notined at | Director | 10a. Stata 10b. County MARYLAND WORC 10e. Street and Number | ESTER | | 10c. City, To | | | Code | | | | 10g. Citizen o | f What Cou | 10d. Inside City Limits 1 ☐ Yas 2 ☑ No |
| | th with | | 13385 ROLLIE R | OAD | | | | 218 | 813 | | | | USA | | |
| 20 | rs after deal | by Funeral | 11. Marital Status 1 □ Never Married 2 ☒ Mar 3 □ Widowed 4 □ Divorced | ried 1 D | ned Force Yes 2 [es. Give | nt Ever in U,S. a? No :: 42/45 | | Was Deced 1 Yes, spec | city Cuba | lispanic Orl an, Mexican Specify: | i, Puerto | ecify Yas or No- Rican, etc.) | | ace - Ameri eck, White | , etc. |
| 9 | 2 hou | | 15. Deceder | nt's Education | | | 6a. Deced | lent's Uaua | i Occup | atlon | | | 16b. Kind of | | ITE |
| Maryland 21215-0020 | thin 7 | Completed | (Specify only highan Elementary/Secondary (0-12) | | leted) lege (1-4o | r 5+) | (Give life. L | kind of wor DO NOT us | rk dona d se retired | during mos d) | t of worki | ing | | | |
| 121 | filed wi Hygien ther th | Con | 10 | | | | ELF | ECTRI | CIAN | | | | ELECT | ~ | |
| and | htal H | Be | 17. Father'a Name (First, Middle, | Last) | | | | | | | | (First, Middle, | Maiden Sum | ame) | |
| 2 | should band Menta | To | RAPHAEL MIRO 19a. Informant's Name/Relations | shin (Tyne Pri | ne) | 1 | Oh Mailie | n Addrage | /Street | (UNKN | | al Routa Numbe | City of Tou | n State 7 | - Codel |
| | d 2 the | | ALICE E. MIRO/ | | 11,7 | | | | | | | OPVILLE | | 2181 | |
| Baltimore, | ages 1 ant of He it: if Itan y or oth | | 20a. Method of Disposition 1 Buriai 2 Coremation 4 Donetion 5 Other (5 | 3 □Remova | I from Stat | 20b. Piaca ceme | of Dispo | | ne of thar plac | се) | 1 | Date | 20c. Location | - City or T | |
| Balti | permit. F Departmo Importan any Injur | | 21. Signature of Funeral Service | Licensaa | l. | 1 | 22 | . Nama an | d Addres | ss of Facilit | ly | ME, SEL | | | |
| | Physician | | 23a. Part T. Enter the disease, or shock, or heart failure. List | r complications only ona caus | that caus a on each | of the death. D | | | | | | - | | | Approximate Interval Between Onset and Death |
| | /Medical Examiner | <u>.</u> | Immediate Cause (Finel disease or condition resulting in death) | a. < | Sef | Due to (or as | a conse | uence of): | | | | | | | 36 m |
| Box 68760, | that the death certificete be executed ed by the ettending physician and deteched for use as the buriel-transit | an/Medical Examiner | Sequentially list conditions, if any, leading to Immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b |) es | Que to (or as | te | No | du | od | en | al n | lei | | |
| P.O. B | t the deat by the eth reched for | Physician/M | Part II. Other significant condition | ons contributin | o to death | but not resulting | g in the ur | ndarlying co | ausa giv | en In Part I | | | obacco use o | 1 | o the cause of death? |
| Records, | been sign should be | by | ageral | 2nd | 1 | arte | n | urc | ler | w | 1 | 24a. Was a | an autopsy med? | a) Ci | fere eutopsy findings vailable prior to empletion of cause |
| Vital Re | The ate h page | e Completed | Chronic of 25. Was case referred to medica | istru | eli | uld | who | ana | 30 | lisé | an | 2 10 Y | | | death? □ Yas 2□ No |
| | Physician: this certific ral director, | To Be | examiner? | Hospital | Inpa | tient 2□ FR/ | Outpatien | t 3 DO | A Oth | er | | me 5 ☐ Resid | | ther (Snec | 60 |
| 0 | ig Physical dispersion of the second dispersio | | 27. Menner of Death Natural 5 Pendir | 28a. | Date of In (Month, D | | . Time of | | 8c. Injun | | | 28d. Describe h | | | 77 |
| Division of | or Att | Certification: | 2 Accident Investi 3 Sulcide 6 Could 4 Homicide determ | getion not be | Place of I | njury - At home, etc. (Specify) | | М | 10 | Yes 2□ | | 28f. Location (S City or Tow | itreet and Num n, State) | nber or Rur | al Route Number, |
| _ | Hospital 14 hours Funeral tely filled | edicai Ce | 29a. Cartifier (Check only one) Certifyir 2 Medical | Examiner: On | To the bes tha basis d manner s | of examination a | lge, death and/or inv | occurred a | at the tim In my op | ne, date an- pinion, dea | d piaca, a | and due to the ded at tha time, o | euse(s) and r date and place | nanner as a a, and due t | atated. o the cause(a) |
| | To the To the comple | Me | 29b. Signature and titla of cartifie | 750 | ho | m | mi | 290 | | a number | 65 | | 29d. Date sign | ned (Month, | Day, Year) |
| | 1111 | | 30. Name and address of person | who complete | d cause of | death /Item 224 |) (Time I | Drint) | | | | | Š. | - | |

State Registrar



State of Maryland / Department of Health and Mental Hygiene 97 27063

| | | | | | | Cei | rtificate o | f Death | | Reg | g. No. | | |
|------------|---|----------------|--|---|--------------------------------|------------------------------|---------------------------------------|---------------------------------|-----------------------------|----------------------------------|------------------|--------------------------|---|
| | | | 1. Decedent's Name (First, Mic | ddla, Last) | | | | | 2 | . Data of Death | | | 3. Time of Death |
| | Physici | | Betty | Має | 3 | | Mass | o v | | Month August | Day 2/ / | Year 1997 | 1645 |
| | /Medi Examir | | 4a. Facility Name (If not institu | | | | 11433 | | | ition of Death | 4c. County | | / . |
| 4 | Exami | ici | PENINSULA REGI | ONAL MEDIC | AI CENTE | 7 D | | | ISBURY | | | OMIC | 0 |
| | | | 5. Social Security Number | 6. Sex | 7. Age (In yrs. la | | If Under 1 Ya | | | | | | |
| | Funeral Director | | | 1□ M 280 F | | 76 Yrs. | Months Day | | Min. | Date of Birth (Month, Day, 1) | | | ace (State or Foreign try) |
| | | | 213-14-1648 Usual Residence of Decedent | | | | | | | JO 11 Z. | i. <u>S</u> | balls | bury, MD |
| | land | | 10a. State 10b. Cour | nty | 10c. City | , Town or Lo | ocation | | | | | 10 | Od. Inside City Limits |
| | the Marylan 28a-f ahow notified at | ō | MD Wi | comico | | 01101 | h | | | | | | X Yes 2□No |
| | 28a | Director | 10e. Street and Number | COMICO | | alisi | 10f. Zip Code | | | 10 | g. Citizen of W | /hat Count | In/2 |
| | W W | | | | | | 101. 2.10 0000 | , | | 101 | g. Oitizen of Vi | mat Oourn | ly: |
| | a 23a | 20 | 209 N. Sar | | | 2 140.1 | 218 | | | 4 14 | U.S. | | - 1- 4 |
| | hems hems | Funeral | 11. Maritai Status | Armed Fo | | | Was Decedent o if Yas, specify Co | r Hispanic Ori Jban, Mexicar | gin? (Speci n, Puerto Ri | ty Yas or No- can, etc.) | | - Amarica k, White, e | |
| 20 | ours after death with the Maryla el', or thems 23s or 28s-f shor Examiner must be notified at | by F | 1 Navar Marriad 2 M | if Yes, Gi | ve | | 1 ☐ Yas XIXN | lo Specify: | | | Specify: | Wh: | ite |
| 21215-0020 | within 72 hours after death with the Maryland ene. than "naturel", or Hems 23s or 28s-f show ta Medical Experient must be notified at | D | | | Pates: | | | | | | | | |
| 5 | 72 | Completed | 15. Deced (Specify only high | lent's Education hest grade completed) | | (Give | dent's Usuai Occ kind of work dor | ne during mos | t of working | 10 | 6b. Kind of Bu | siness/Ind | ustry |
| 12 | Par S | d E | Elementary/Secondary (0-12 | College (| 1-4or 5+) | IITO. I | DO NOT use reti | rea) | | | | | |
| | hed v | | 11 | | | | Housew: | | di N | Fi | None | | |
| an a | be find of other | B | 17. Father's Nama (First, Midd | | | | | 18. Mothe | ers Name (i | First, Middle, Me | alden Sumam | Θ) | |
| Maryland | s i and 2 should be filed within 72 hc Health and Mental Hygiene. tem 27 is marked other than "natur other treumatic event, II's Medical | 2 | George Fi | | White | | | | | Mae | | ith | |
| Ja | 2 sh and le m | | 19a. Informant's Name/Relation | enship (Type, Print) | | 19b. Maille | ng Address (Stre | et and Numbe | er or Aurai I | Route Number, | City or Town, | Stete, Zip | Code) |
| | Health Health Jem 27 I | | Calvin L. Mass | ey,III-Son | | 31620 | 01d 0ce | ean Cit | ty Roa | | | | |
| ore | ges 1 ar t of Hea if Item or othe | | 20a. Method of Disposition X ☑ Buriai 2 ☐ Cramatio | n 2 Demovel from | | ace of Dispo metery, crer | osition (Neme of matory or other p | elace) | | Date 20 | Oc. Location - | City or To | vn, Stete |
| Ē | Pag nent int: I | | 4 Domation 5 Other | | | nghil | 1 Memory | v Garde | ns 8 | 25/97 F | lehron | MD | |
| altimore, | permit. Pages 1 Department of F Important: if its any injury or ot | | 21. Signature of Funeral Servi | ce Licensee | M01051 | | 2. Name and Add | | | lloway I | | | D 1 |
| 0 | 885 8 | | D X Jack | 91 10- | moros | | 01 Snow | H-111 T | | | | | 804 |
| | | | 23a. Part 1. Enter the disaase, | or complications that | causad the death. | | | | | | - | 2 1 | Approximate |
| | Physician | | shock, or heart feilure. L | ist only one ceuse on e | ach line. | | | , | | | | | Intervel Between Onset and Death |
| 0 | /Medical | | immediate Ceuse (Finai | C. | / - | , | 0 | 4 | . 10 | + | | | |
| 1 | Examiner | | disease or condition resulting in death) | a | 11000 | vesc. | ven | acci | der | <i>n</i> | | | |
| | | ě | | n | 11600 Due to (or | as a consec | guenca of): | h | m. | | | | |
| | nsit | Examiner | | b | | | | allori | | | | i | |
| | entificate be executed ding physician and se as tha burial-transit | xai | Sequentially list conditions, if any, leading to immediate | | Due to (or | as a consec | quence of): | | | | | i | |
| 68760, | be | | cause. Enter Underlying Cause (Disease or injury that initiated events | С | | | | | | | | | |
| 387 | phy: | /Medical | resulting in death) Last | | Due to (or | as a conseq | juence of): | | | | | 1 | |
| × | nding p | N. | | d | | | | | | | | | |
| 80 | ath ittar | Jan | | | | | | | | | | | |
| Ö | 0 0 | Physician | Part ii. Other significant condi | itions contributing to de | eath but not resul | lting in the u | nderlying cause | given in Part i | | 23b. Did tob | acco use con | tributa to | the cause of death? |
| 9 | The law requires that the ste has been signed by th page 2 should be datache | | | | | | | | | 1 🗆 Yes | 2 No | 3 Prob | ably 4 Unknown |
| S, | es ti gne be d | by | | | | | | | | | | | |
| Records, | v require been si should I | ted | | | | | | | | 24a. Was an perform | | ava | re autopsy findings illable prior to |
| O | has be | ple | | | | | | | | | | | npietion of causa leath? |
| 0 | The la | Completed | | | | | | | | 1 Tes | 2 134No | 10 | Yes 2 No |
| Vital | | 0 | 25. Was case referred to medi | cai | | | | 26. Place | of Death | Check only one |) | | |
| > | Physicien: this certific ral director, | 0 B | examiner? 1 ₹ Yes 2 No | Hospitel: 1 M | inpatient 2 🗆 E | R/Outpatier | nt 3 DOA | Other: | | 5 🗆 Residen | | er (Specify | 0 |
| of | | j. | 27. Manner of Death | 28a. Date | of Injury | 28b. Time of | | - | - | d. Describe how | | | |
| O | nding P nth. : After a funer | atio | 1 Netural 5 Pen | ding (Mon stigetion | th, Dey Year) | Injury | | Yes 2 | No | | | | |
| Division | if or Attending efter death. Director: After d in by the fune | E C | 3 ☐ Suicide 6 ☐ Cou | rmined 286, Piece | of Injury - At hor | ne, farm, str | reet, factory, offic | :0 | 28 | f. Location (Stre | | er or Rurai | Route Number, |
| Ö | afta Dir din | Certification: | 4 ☐ Homicide | buildi | ng, etc. (Specify) |) | | | | City or Town, | Stete) | | |
| | To the Hospital or A within 24 hours aftar To the Funeral Dire completaly filled in b | | 29a. Certifier 12 Cartify | ying Physician: To the | best of my know | rledge, deeth | occurred at the | time, date an | d piaca, an | d due to the cau | use(s) and mai | nner as st | ated. |
| | Ho Fu Jetah | edical | (Check only 2 Medic | ai Examiner: On the b | asis of examination of stated. | on and/or in | vestigation, in my | y oplnion, dea | th occurred | at the time, dat | e and plece, a | ind due to | the cause(s) |
| | Vithir omp | Me | 29b. Signature and title of our | | | | | nsa number | | | d. Date signed | | Day, Year) |
| | ,- > - 0 | | XN | // | | | 50 | 1540 | 0 | | 8/22 | 197 | |
| | / | | 20 Name and officers of | | a of death die | 00-1/7 | Deleth | | | | / / | // | |
| | 6 | | 30 Name and address of pers | completed caus | or death (Item | ∠Ja) (Type, | 1/1 | le mile | 010 .5 | T. 3AL | BUIL | PI | |
| | Q | | 31. Date filed Month Day Ye | HOT /100 | distract Sinn | Pro. 1 10 | (-1). /0 | - | | | 1 | - | |
| | Sta Registr | | AUG 221 | 99/ Julia | se of death (Item | proble | | | | | | | |

Beth Massey

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Physician /Medical Examiner

Veronica Alta 4e. Fecliity Nama (If not institution, giva street and number) Mitchell

2. Dete of Deeth Month 30, 1997 July

3. Time of Death 2:40 PM

Route 5 Southbound Lane 5. Social Security Number 7. Age (In yrs. last birthdey)

4b. City, Town, or Location of Deeth Mechanicsville

4c. County of Death St. Mary's

Funeral Director

must be notified at

ò Нете 23а

permit. Pages 1 and 2 should be filled within 72 hours affer. Department of Health and Mental Hygiene, important: if Nem 27 is marked other than "naturel", or Nem eny Injury or other traumatic event, tte Medical Exercises

Physician /Medical

Examiner

pue

physician el s the burief-t

for use as

ed by the a

should be data

certificate has lirector, page 2 s

Hospital or Attending Physician: 24 hours aftar deeth. Funeral Director: After this certifica italy filled in by the funeral director, I

To the Mospital of within 24 hours a To the Funeral Completally filled in the Total Completal Comple

Physician/Medical

þ

Be Completed

Certification: To

Pert II

The law requires that the death certificate be executed

P.O. Box 68760

Records,

Division of Vital

Baltimore, Maryland 21215-0020

the Marylend

Usuel Residence of Decedent 10a State 10b. County

1. Decedent's Name (First, Middle, Last)

10c. City, Town or Location

Vrs.

If Under 1 Yaar If Under 24 Hrs.
Months Deys Hours Min. 8. Date of Birth (Month, Dey, Year) Aug 15, 1912

 Birthplece (State or Foreign Country) Illinois

10d. Inside City Limits

1 Yes X No

28a-f show

Director

Funeral

þ

Completed

Maryland St. Mary's

388-32-2294

California

10g. Citizen of Whet Country?

Specify:

10e. Street end Number

23140 Cobblestone Lane

1□M 280 F

10f. Zip Code 20619

U.S.A.

1 Nevar Married 2 Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Yeer or Detes:

84

13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, atc.) 1 ☐ Yes 2 ☑ No

14. Rece - Amarican Indian, Black, White, etc.

White

15. Decedent's Education (Specify only highest grede completed)

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)

Deys

16b. Kind of Business/Industry

Elementery/Secondery (0-12)

College (1-4or 5+) 2 Years

Medical Records Librarian

Hospital

17. Father's Neme (First, Middle, Last)

Thomas

Adams

Beattie

Beatrice Mary Jane

18. Mother's Name (First, Middle, Meiden Sumeme)

Harris

19e. Informent's Neme/Reletionship (Type, Print)

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) P.O. Box 850, Lusby, MD 20657

Alta Gwynn Mitchell/Daughter 20e. Method of Disposition

1 ☑ Burial 2 ☐ Cremetion 3 ☑ Removel from Stata

20b. Plece of Disposition (Neme of cemetery, cremetory or other place)

Dete 20c. Location - City or Town, Stete

8/9/97

4 ☐ Donetion 5 ☐ Other (Specify)

Rock Island Mem. Park 22. Name end Address of Fecility

Rock Island, Illinois

21. Signature of Funeral Service License

al

Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

23e. Pert1. Enter the disease, or complications that ceused the c shock/or heart failure. List only one ceuse on each lina. Immediate Ceuse (Finel

Multiple Trauma

Sec.

diseesa or condition resulting In deeth)

Due to (or es e consequence of):

Auto Accident

Due to (or es e consequence of)

Due to (or es e consequence of):

Examiner

Sequantially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceusa (Disaese or Injury that Initiated events rasulting in deeth) Lest

| Other significant conditions | contributing to death but no | ot resulting in the underly | ing ceuse given in Per |
|------------------------------|------------------------------|-----------------------------|------------------------|

23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24e. Wes en eutopsy performed?

24b. Were eutopsy findings evalleble prior to completion of ceusa of deeth?

1 Yes 2 No

1 ☐ Yes 2 No

25. Was cese referred to medical 1X Yes 2 No

1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 28b. Time of

28c. injury et Work?

Other: 4 Nursing Home 5 Rasidence 8 Mother (Specify) Highway 28d. Describe how injury occurred

26. Piece of Deeth (Check only one)

27. Manner of Deeth 1 Neturei 2 X Accident

5 Pending invastigation 6 Could not be determined

Injury Jul 30, 1997 14:40^M

1 Yes 2 No

Auto Accident

29e. Certifier

3 Suicide

4 Homlcide

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) Highway, Mechanicsville, MD 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Highway

Leonardtown, Maryland

200. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es stated. 2 Madical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, end due to the ceuse(s) end manner steted. 29c. License number 29d. Date signed (Month, Dey, Year)

D14285

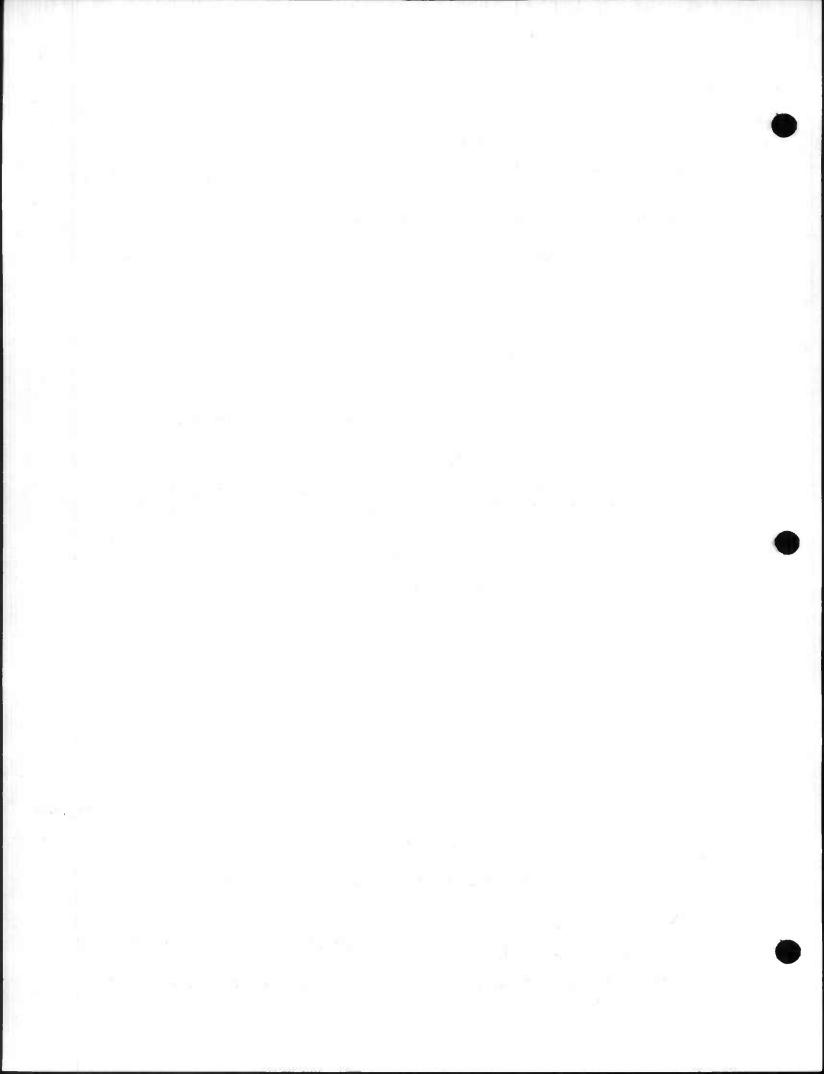
William D. Boyd, II, M.D. 31. Dete filed (Month, Day, Year) AUG 5

July 31, 1997

30. Neme end eddress of mi rson wo ceuse of deeth (Item 23e) (Type, Print)

State Registrar 32. Begistrere Signature Randall

DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene 97 27065

| _ | | | | | | | - | | ificate of | Death | | | Reg. No. | | | | |
|------------|---|----------------|--|---|------------------------|----------------|---------------------|---------|---------------------------------------|---------------|------------|-----------------------|------------------------|------------------|---------------|---------------------------------|------|
| | Physic /Medi | | 1. Decedant's Nam | PH R. | Josep MAT | h Ry: | an Matth KS | ews | s, Sr. | | | 2. Data of D Month | Day Day | 19 | 99 | 3. Time of Deel | |
| | Exami | | 4e. Facility Nama (| | ve street and nu | um <i>ber)</i> | | | | 4b. City, To | wn, or Lo | cation of Dea | th 4c. (| County of | Death | 1 | |
| | | | PRINC | E GLEOK | GES H | BRITI | AC CEN- | TEX | | CHEV | ERL | 1 | PR | INCE | GE | ORGES | |
| | Funeral | | 5. Social Security N | | Sax | 7. Aga (| In yrs. last birthd | | If Under 1 Year | if Undar | | 8. Date of B | irth | 9 | . Birthpie | ece (State or For | aign |
| | Director | | 219-16-07 | 57 | 1 ■ M 2□ F | 70 |) Yrs | . ! | Months Days | Hours | Min. | December | r 17.19 | 26 M | lary | land | |
| Н | 73 | | Usual Residence o | | | | | | | | | | | | | | |
| | land | 1 | 10a. Steta | 10b. County | | 1 | Oc. City, Town or | Loca | ation | | | | | | 10 | d. Insida City Lin | nits |
| | within 72 hours efter deeth with the Maryland ene. than "natural", or frems 23a or 28a-f show ha Medical Examinet must be notified at | Director | Maryland | St. Mary | S | | Valley | Le | | | | | | | | 1 Yas 2 | No |
| | £ 8 | 늄 | 10e. Street and Nu | mber | | | | | 10f. Zip Coda | | | | 10g. Citiz | en of Wha | at Count | ry? | |
| | 23a | | 45201 Sh | etland A | cres Dr | ive | | | 20692 | | | | Unite | d St | ates | | |
| | 8 8 5 | Funeral | 11. Maritel Status | | 12. Was Dec | cedant Ev | ar in U,S. 1 | 3. Wa | as Decedant of h | lispenic Or | igin? (Spe | cify Yee or N | 10- 1 | 4. Race - | | | |
| 0 | of the mark | E | 1 🗋 Nevar Marr | ied 2 Married | 1 Tas | 2 No | | | | | | riioari, etc.) | | Black, | Whita, a | ic. | |
| 020 | 5 | by | 3 ☐ Widowed | 4 Divorced | If Yas, G Yaar or (| ive Datas: | | 1L | ☐ Yas 2 No | Specify: | | | | Specify: | Whit | e | |
| 21215-0020 | should be filed within 72 hours eft of Menial Hygiene, marked other than "natural", or imatic event, tha Medical Exami | | | 15. Decedent's E | ducation | | 16a Da | ceda | nt's Usuai Occur | ation | | | 16b Kin | d of Busin | | | |
| 15 | n 7 | Completed | (Space | cify only highest gr | ada complated, |) | (G | iva kil | ind of work done O NOT use retired | during mos | t of worki | ing | 100 | | | | |
| 12 | with han | 물 | Elementary/Seco | ondery (0-12) | Coilege | (1-4or 5+) | | | | -/ | | | | | | | |
| | Hygie Hygie ont, Et | ပ္ပ | 12 | | | | Go | nt | ractor | | | | _ | onst | | ion | |
| DO | ould be filed with Mental Hygiene. arked other than atic event, the | Be | 17. Fathar's Nama | (First, Middla, Las | t) | | * | | | | | (First, Middle | | Su <i>m</i> ema) | | | |
| <u> </u> | Aleni | To | William R | yan Matt | hews | | | | | Leon | na M. | Coppa | ige | | | | |
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| | Vill To Cou | | 29b. Signature and | title of certifier | // | / | ١. | | 29c. Licens | e number | | | 29d. Dete | signed (# | Month, E I | lay, Year) | |
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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 👩 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death August 5, 1997 William Joseph Medley, Sr. 5:25 PM 4a. Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Hollywood If Undar 24 Hrs. 8 Hours Min. Three Notch Road Mary's If Undar 1 Yaar 5. Social Sacurity Number 7. Age (In yrs. last birthdey) 8. Data of Birth (Month, Dey, Year) Birthplaca (Steta or Foreign Country) Months Days 1 € M 2 □ F Yrs. 220-16-7405 Feb 14, 1927 Maryland Usual Residence of Deceden 10e Stete 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland St. Mary's Hollywood 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Three Notch Road 20636 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2€No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yas 2 € No Specify: Specify: Black 3 ₩ Widowed 4 Divorcad 16e. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highast grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8th Grade Farmer Farm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Joseph Medley Marie 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 52Spring Hill Road, Lexington Park, MD Joseph W. Medley, Jr./Son 20653 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removel from State Queen of Peace CEmetery 8/11/97 4 ☐ Donation 5 ☐ Other (Specify) Helen, MD 21. Signiffure of Funeral Service Lice 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 23a. Part 1. Enter the disaasa, or complications that caused the deeth. Do not antar the mode of dying, such es cardiac or raspiratory arrest, shock, or heert failure. List only one cause on each line. 20650 Approximate Interval Between Onset and Death nate Immadiate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Part It. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24e. Was en autopsy performed?

Physician /Medicai Examiner

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certificate

After

Director:

To the Hospital within 24 hours a To the Funeral Complataly filled

funeral

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Medical Certification:

Hospital or Attanding Physician: 24 hours after death.

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Box 68760

P.O.

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Division of Vital

Physician

/Medical

Examiner

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item 27 le marked other than "natural", or itema 23a or 28a-1 ehow other traumatic event, the Mod cal Exampar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or ites any injury or other traumatic event, its Most and Examinat

Baltimore, Maryland 21215-0020

the Maryland

death

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Physician/Medical þ Completed

28a. Date of Injury (Month, Dey Year)

24b. Were autopsy findings available prior to completion of cause of deeth? 1 Yas 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 1 Residence 8 ☐ Other (Specify) 28d. Describe how Injury occurred 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

25. Wes case referred to medical examiner? 1 Yes 2 No 27. Manner of Deeth 1 Natural

5 Pending Investigation 2 Accident 6 Could not be determined 4 Homicide

Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

29e, Certifier

3 ☐ Sulcide

15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete end place, and due to the ceuse(s) and magner stated. 29c. License number

29b. Signatura and title of cartifier

D3a65

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Dey, Year)

3

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Hospital:

Bhaskar Jhaveri, 31. Dete filed (Month, Dey, Year)

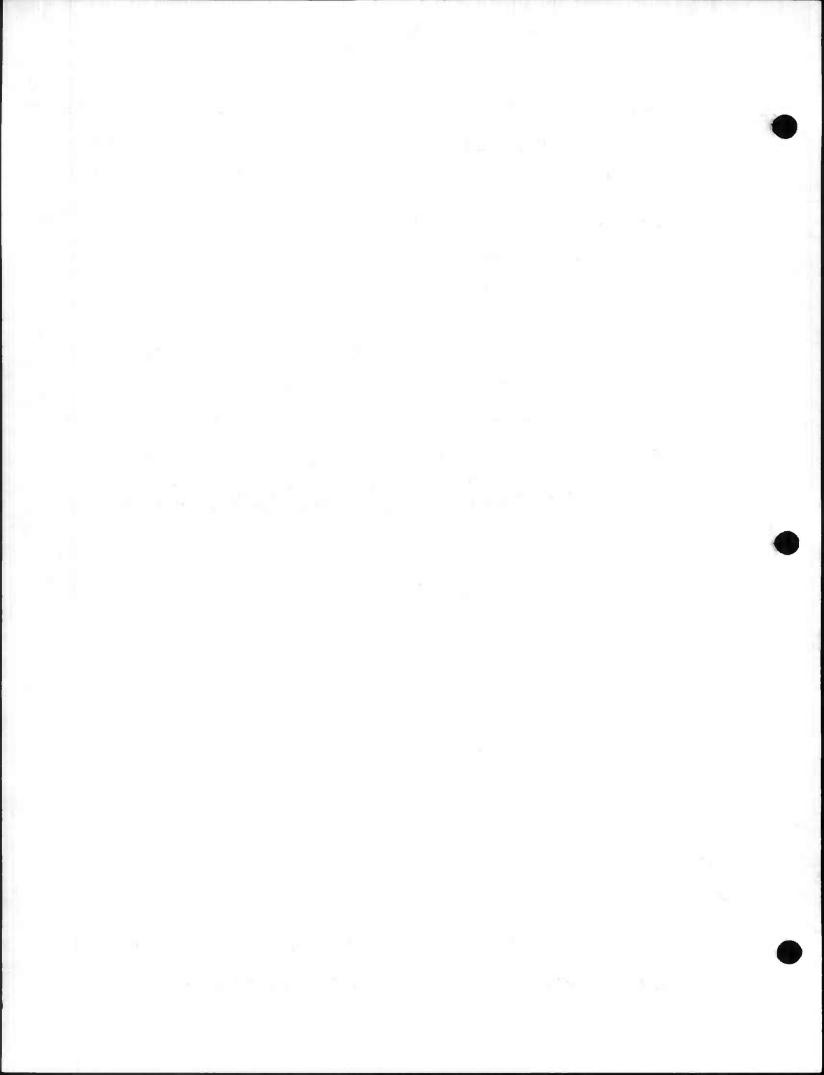
Hollywood, Maryland

State Registrar

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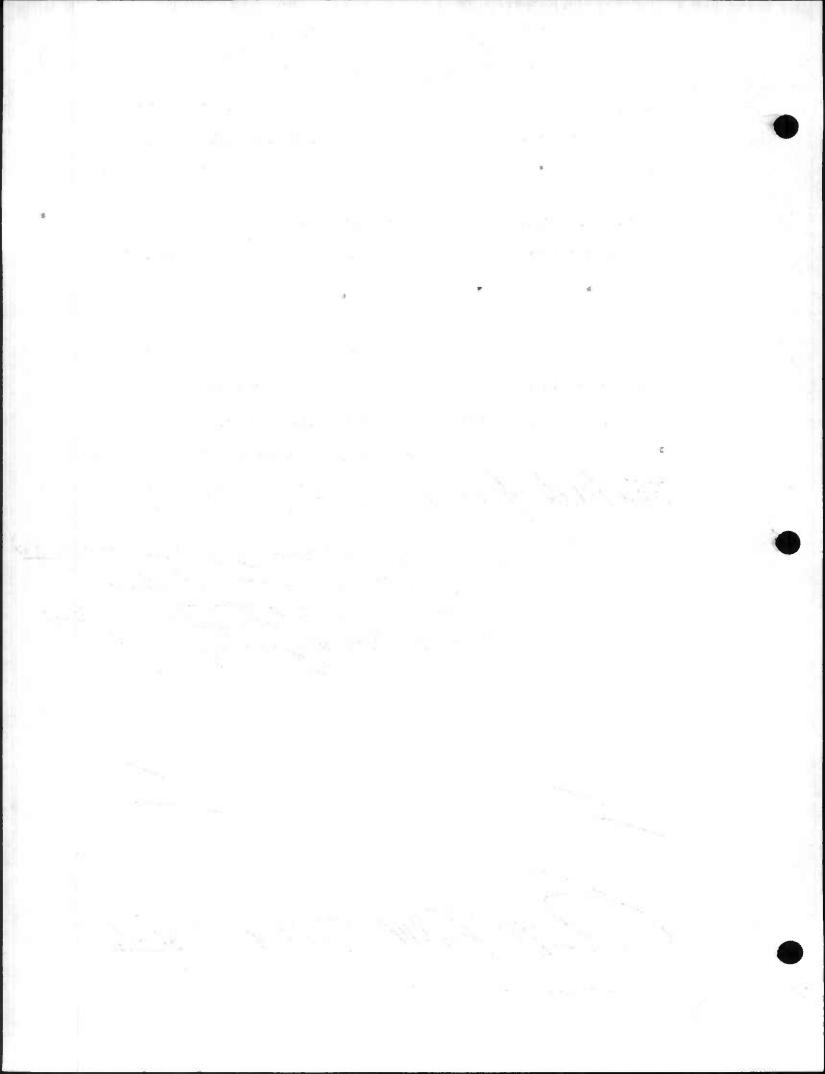
32. Registrar's Signature
Sabia Savelon Randall

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 97 27067

| | | | | | · · · · · · · · · · · · · · · · · · · | | ificate of | | Re | ig. No. | 1 6 | 1061. |
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| я | Dhusia | ion | 1. Decedant's Nama (First, Middle | a, Last) | | | | | 2. Data of Deat Month | Day | Year | 3. Time of Death |
| | Physic: /Medi | | Charles Joseph | | | | | | August ' | ا7 , " 199 | 7 | 7:30 AM |
| | Examir | | 4a. Facility Nama (If not institution | , giva straat and numb | ber) | | | 4b. City, Town, or | Location of Deeth | 4c. County | of Death | |
| 7 | | | 45918 Patuxent | Lane | | | | Lexingto | n Park | St. | Mary's | 5 |
| 65 | Funeral | | 5. Social Security Number 185–10–1824 | 6. Sax 1 ■ M 2 □ F | . Age (In yrs. I | | If Undar 1 Yeer Months Days | | | Year) 1910 | 9. Birthpled Country De Lawa | ca (Stata or Foreign |
| | pu , | 1 | Usual Residance of Dacedant | | | | | | | | | |
| | anyte ohow | | 10a. Stata 10b. County | | 10c. City | , Town or Loca | tion | | | | 10d. | Insida City Limits |
| | No M | 5 | Maryland St. N | Mary's | | Lexi | ington 1 | Park | | | | 1 ☐ Yas 2 ■ No |
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| | th w | <u>a</u> | 45918 Patuxent | : Lane | | | 206 | 53 | | United | l State | es |
| 21215-0020 | 2 should be filed within 72 hours after death with the Marylend and Mental Hygiene. Is marked other than "naturel", or items 23a or 28=4 show surnatic event, the Medical Examiner must be notified at | by Funeral Director | 11. Marital Status 1 □ Nevar Married 2 ■ Marr 3 □ Widowad 4 □ Divorced | 12. Was Dacede Armed Forci ied 1 Yas 2 If Yas, Give Year or Data | as? | | as Decedant of Yas, specify Cub | Hispenic Origin? (Span, Maxicen, Puar Specify: | Specify Yes or No- to Ricen, atc.) | | e - American ck, Whita, etc | |
| Õ | hou | | 15. Dacedani | | | 16a Deceder | nt's Heual Occu | nation | | 6b. Kind of B | | |
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| 12 | with ene. | mc | Elamantary/Secondary (0-12) | Collaga (1-4 | for 5+) | | lectric | | | Unic | on Work | leon. |
| | Hyg Hyg | | 17. Fathar's Nama (First, Middla, | Last) | | | ICCCI IC | _ | ma (First, Middla, A | | | /er |
| Maryland | s 1 end 2 should be filed within 72 hc Health and Mental Hygiene. tem 27 is marked other than "natur other treumatic event, the Medical | o Be | Francis A. McC | | | | | | a Allen | | | |
| 2 | d Me d mark mark | 2 | 19a. Informant's Name/Relations | | | 10h Mailing | Address (Ctros | | | City as Taura | Chata Zia Ca | - d-1 |
| Z | | | Nellie E. McGl | | Wife | | | | ural Route Number, on Park, N | | | |
| | f Health Item 27 other tr | | 20a. Mathod of Disposition | .aue, | | ace of Disposit | | Lexingle | | Oc. Location - | | |
| ō | 00- | | 1 Burial 2 Cramation | 3 Ramoval from St | CE | ematary, crama | tory or other ple | | | | | |
| tir | nit. Pa entmen ortant: injury | | 4 Donation 5 Othar (S) | - 4/ | Evel | rgreen | Memoria | I Garden | s 8/20/97 I | exingt | on Par | K, MD |
| Baltimore, | permit. Pag Depertment Important: It any injury o | | 21. Signature of General Survice | 6 |) Nuc | Dec | insfiel | 3 D | l Home, F | .A. | | 20552 |
| | _ | | 23a. Pert1. Enter the diseesa, or shock, or heart failure. List | complicate is that cau | sed tha daath | Do not enter | the mode of dy | LIYWOOD R | oad, Leor c or respiratory erra | ardtow st, | n, MD | 20650 pproximate |
| | Physician / /Medical Examiner | er. | Immediete Causa (Final diseasa or condition resulting in daath) | | De 18 (01 | as a conseque | rice of): | mono | y / | nin | Ö | itarvel Batween inset end Deeth |
| Box 68760, | the death certificate be executed y the ettending physician and sched for use as the bunal-transit | Physician/Medical Examiner | Sequantially list conditions, if eny, leading to immadiate causa. Entar Undarfyling Causa (Disaasa or Injury that Initiated avants resulting In daath) Last | 6. Z | Dug to (or | a conseque | noe ot: | Ulsa Olsa ry i | heel. | ne , | 9. | 200 |
| | be el | sici | Part II. Other significant condition | ns contributing to deat | th but not rasu | Iting in the und | arlying ceusa gi | van in Part I. | 23b. Did to | pacco use co | ntribute to th | ne cause of death? |
| P.O | et the de I by the e steched | Phy | | | | | | | 1 □ Ye | 8 2 No | 3 Probab | oly 4 Unknown |
| Ś | ss thet gned t | by | | | | | | | | | | |
| Record | The law requires thet ate hes been signed b page 2 should be dete | Completed | | | | | | | 24e. Wes ar perform | | availa | autopsy findings able prior to eletion of ceuse eth? |
| | | ပ္ပ | | | | | | | 1 □ Ya | s 20 No | 1 □ Y | ′as 2□ No |
| Vital | ician: The certificate rector, pag | Be (| 25. Wes cesa raferred to medical axaminar? | | | | | 26. Place of De | eth (Check only on | 1) | | |
| of V | ysic dire | ဥ | 1 Yes 2 No | Hospitel: 1 ☐ Inp | atiant 2 🗆 8 | ER/Outpetient | 3 DOA Ot | her: 4 Nursing F | loma 5 Areside | nce 6 Oth | ar (Specify) | |
| | | | 27. Mannar of Death | 28a. Data of I | Injury Day Year) | 28b. Tima of Injury | 28c. Inju Wo | ry at | 28d. Dascribe ho | w injury occur | red | |
| Ö | Attending ir death. octor: After by the fune | atio | 1 ☐Natural 5 ☐ Pending 2 ☐ Accidant invastig | 9 | Day roary | IIIĮury | | Yas 2 □ No | | | | |
| Division | 5 # 5 E | Certification: | 3 ☐ Sulcide 6 ☐ Could n 4 ☐ Homlcide datarmi | ned 286. Piece of | f Injury - At hor i, etc. (Specify) | | t, factory, office | | 28f. Location (Str. City or Town | | ear or Rural R | outa Number, |
| | To the Hospital within 24 hours a To the Funeral Completely filled | | 29a. Certifier 1 Geraryth | I iclan: To tha be | est of my know | vledge, daath o | ccurred at tha ti | ma, data and place | , and due to the ce | usa(s) and ma | nnar as state | ed. |
| | n 24 n 24 ne Fu | edicai | (Check only 2 Medical E | on the basis and mannar | s of axamineti | on end/or invas | itigation, in my | opinion, death occu | irred at the tima, de | te end plece, | and dua to the | a ceuse(s) |
| | Mithii To th | M | 29b. Sanature and title of certified | m | / | 1/11/ | 29e Liceg | June //c | 25 | d. Date sime | d (Magh, Da) | y, Year) |
| | , - 0 | | 11/m | 4/1/3 | Tu | 411 | | 19170 | 7 | 816 | 18/ | |
| | (| | 20 Name or dedday | 1 6 0 | | 00-1 79 | | | | 1-1 | | |
| 6 |) | | 30. Name end eddrass of person v | | | | | | | / | | |
| | | | David M. Fede 31. Data filed (Month, Day, Year) | rle, M.D. | 24035 | Three | Notch R | Road, Hol | lywood, M | arylan | d-2063 | 6 |
| | Sta | te | ALIC 2.1 | 1997 | A Signati | ura Randall | | | | | | |



State of Maryland / Department of Health and Mental Hygiene 27068 Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death 3. Time III Death **Physician** MORGAN teur 1628 25 /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, giva street and number) 4c. County of Death **Examiner** 7. Age (In yrs. last birthday) If Undar 1 Arundel ANNApolis Gen. If Undar 1 Year 5. Social Security Number 6 Sax If Under 24 Hrs. **Funeral** 1₽M 2□ F Months Days Hours Yrs. Director Aug 6, 1935 Maryland 220-34-4200 the Maryland 10a. State 10c. City, Town or Location 10b County 10d. Insida City Limits show r than "natural", or items 23a or 28a-f short the Medical Examiner must be notified at Maryland Anne Arundel Harwood 1 Yas X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 20776 U.S.A. 1503-B Flanders Lane Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ∰Yas 2 □ No If Yas, Giva Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Maxicen, Puerto Ricen, etc.) 14. Race - Amaricen Indian. Black, Whita, atc. 72 hours after 1 ☐ Navar Married 2 ☑ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade complated) permit. Pages 1 and 2 should be filed within.
Department of Heelth and Mental Hygiene.
Important: If fem 27 is merked other than any Injury or other trauments. Painting and Elamantary/Secondary (0-12) Collaga (1-4or 5+) Construction Company 12th Grade Supervisor Contractor 17. Fathar's Name (First Middle Last) 18. Mothar's Nama (First, Middla, Meiden Sumema) Be Morgan Pearl Louise Hayden 2 William Henry 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 1503-B Flanders Lane, Harwood, MD 20776 Agnes V. Morgan/Spouse 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☑ Burlal 2 ☐ Cramation 3 ☐ Ramoval from Stata Charles Memorial Gardens 8/29/97 4 ☐ Donation 5 ☐ Other (Spacify) Leonardtown, MD 21. Signatura of Funaral Sarvice Lia 22. Nama and Addrass of Facility Mattingley-Gardiner Funeral Home, P.A. Part 1 Enter tha disaasa, or complications that ceusad the death. Do not antar tha moda of dying, such as cerdiac or raspiratory arrast, shock or heart failura. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** /Medical Immediate Cause (Final Mypeandial disease or condition rasulting in death) Examiner Examiner teriosa levotic burial-transit Sequentially list conditions, if any, laading to Immediata causa. Entar Underlying Causa (Disaase or Injury that initieted evants resulting in daath) Last and Due to (or es e consequance of): P.O. Box 68760, physician 8 Physician/Medical the Dua to (or as a consequence of): USB BSU guipu atten jo signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, þ should I 24b. Wara autopsy findings available prior to Completed 24a. Was an eutopsy performed? completion of ceuse of death? page 2 hes 1 Yas 2 No 1 ☐ Yas 2 ☐ No cartificate 25. Wes casa rafarred to medical Be 26. Plece of Deeth (Chack only ona) exeminar? Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 10 Yes 2□ No Aftar this funeral 27. Mannar of Deeth 28e. Date of Injury (Month, Day Yaar) 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury at Work? Medical Certification: To the Hospital or Attending within 24 hours effer death.

To the Funeral Director: Aftr Attending 1 Netural 2 Accidant 5 Pending Invastigation 1 ☐ Yas 2 ☐ No 6 Could not be datarminad 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To tha best of my knowledga, daath occurred at the tima, data and place, and due to the ceusa(s) and menner as stated.

Medicel Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29a. Cartifier (Check only one) 29b. Signatura and titla of certifian 29c. Licansa number 29d. Date signed (Month, Day, Year) eputes 8 30. Nama and address of person who completed ceusa of deeth (Item 23a) (Type, Print) 11/1 Ane ones mn 695 1997 July Dhurden Randall 31. Date filed (Month, Dey, Yaer)

DHMH 16 Rev 6/95

State Registrar

State of Maryland / Department of Health and Mental Hygiene

27069

| | | | | | | Cer | tificate of | f Death | 7 | | Reg. No. | | 21000 |
|-------------------|--|---------------|--|--|----------------|------------------------|--|----------------------------|------------------------------|--------------------------------|---------------------|------------------------------|-------------------------------------|
| ï | | | 1. Decedent's Name (First, Middle, | Last) | | | | 1 | T | 2. Date of De | ath | | 3. Time of Death |
| ı | Physic | | Bruce Delwin Mar | rtin | | | | | Z | Month | 27, 199 | Yaar 97 | 12:45PM |
| | /Medi Examiı | | 4a. Facility Name (If not institution, | The state of the s | or) | | | 4b. City, To | | ation of Deatl | - | | 12.13111 |
| 1 | Exum | 101 | 23902 Old Chapt | ico Wharf I | heo9 | | | N | Maddox | , | | St. Ma | mile |
| 8 | Funeral | | | | | last birthday) | if Undar 1 Yea | | r 24 Hrs. | 8 Date of Bir | th | | laca (Stata or Foreign |
| | Director | | 529-28-8738 Usual Residence of Decedent | 1 ■ M 2□ F | 69 | Yrs. | Months Day | s Hours | Min. | (Month, Da | y, Year) 9, 1927 | Uta | try) |
| | yland mow | | 10a. State 10b. County | | 10c. City | y, Town or Lo | cation | | | | | 10 | 0d. Inside City Limits |
| | d within 72 hours efter death with the Maryland jiene. "natural", or items 23a or 28a-1 show the Medical Evaning must be notified at | Director | Maryland St. I | Mary's | M | laddox | 404 700 004 | | | 1 | | | 1 ☐ Yes 2 ■ No |
| | E O E | | | | | | 10f. Zip Code | | | | 10g. Citizen of | What Count | try? |
| | a 23 | Funeral | 23902 Old Chapt | | | - 1 | | 621 | | | | ed Sta | |
| | er de | nu | 11. Marital Status | 12. Was Deceder Armed Forces | 5? | S. 13. V | Vas Decedent of Yes, specify Cu | Hispanic Or ban, Maxica | rigin? (Spec in, Puerto R | cify Yes or No licen, etc.) | | ce - America ck, Whita, a | |
| 20 | s eff | by F | 1 ☐ Naver Married 2 ☐ Marria 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give | | | ☐ Yes 2 No | Specify | r: | | Specif | y: | |
| Ş | hour | | | Year or Datas | : WWIJ | | 4.11.10 | THE WAY | | | | | nite |
| 21215-0020 | c - 6 | Completed | 15. Decedent's (Specify only highest | grada completed) | | (Give i | ent's Usual Occi kind of work don OO NOT use retir | e durina mos | st of workin | g | 16b. Kind of B | usiness/ind | lustry |
| 12 | filed within Hygiena. Hygiena. Ither than "rent, the Mag | E G | Elementery/Secondary (0-12) | College (1-4o | r 5+) | | | , | | | | | |
| 7 | il Hygie other | | 17. Father's Name (First, Middle, La | 8 | | G | eologist | | anda Alama | (Plant Adiabath | Geolo | J 4. | |
| an | S is b | Be | -000 | 191/ | | | | | | | Maroen Surnan | 10) | |
| Ē | should be and Mental marked o | 2 | Raymond Martin | | | 1 | | | ne Sm | | | | |
| Maryland | C1 W T 00 | | 19a. Informant'a Name/Reletionship | | | | g Address (Stree | | | | | | |
| as a | os 1 end of Health item 27 other tr | | Hope M. Martin, | wiie | Tool o | | | ue cour | t, Apt | | | | land 20619 |
| altimore, | M ite | | 20a. Method of Disposition 1 ☐ Burial 2 ■ Cremation 3 | ☐Removal from State | a Cé | emetery, crem | sition (Name of natory or other pi | , | i | Data | 20c. Location | | |
| Ë | Pag men ant: | | 4 ☐ Donation 5 ☐ Other (Spe | | Met | ropoli | tan Cre | matory | 7 8 | 28/97 | Alexand | lria, | Virginia |
| a | permit. Pages 1 Depertment of H Important: If ite any injury or ot | | 21 Signature of Fuher II San Li | of our | | 22 Br | Name and Add | ress of Facil | eral F | Iome I | Σ Δ | | |
| m | 205 2 2 | | Michael K. B. | lankenship | | | | | | | | . Mar | yland 206 |
| | | | 23a. Part 1. Enter tha disease, or co | emplications that cause | ed the death | | | | | | | | Approximete |
| п | Physician | | shock, or heart failure. List or | ny one cause on each | iine. | | | | | | | | Interval Between Onset and Death |
| | /Medicai | | Immediate Cause (Finel | Po | Mark | 100 | 4 | | | F. 16 | 4 - 33 | - | Con |
| | Examiner | | disaase or condition resulting in death) | a. proc | PAR |) r- | Myoc | ARG | ext. | HULL | 4Rella | | 360 |
| _ | | ē | | | D09 01 (01 | r as a consequ | uerice orj. | | | | | 1 | |
| | icate be axecuted physician and s the burial-transit | Examiner | Consumation that are distance | b. ——— | Due to for | es e consequ | unner of): | | | | | | |
| ć | ertificate be axecuted ding physician and se as the bunal-transit | Exa | Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying | | Due 10 (01 | es e consequ | delice of). | | | | | 1 | |
| 68760, | e be rsicia | edicai | Ceuse (Disease or injury that initiated events | C | Due to /or | as a consequ | ionoo off: | | | | | | |
| 68 | ificat g phy as th | 8 | resulting In death) Last | | Due to (or | as a consequ | ierice oi). | | | | | | |
| XO | 0 2 3 | M | | d | | | | | | | | | |
| 0 | that the deeth led by the atter detached for u | Physician | Part # Other significant appdition | a a contaile cotta a tar atara te | h | teles a fee also con- | 4-4-2-2-2-2-2 | | | DOL DIA | | | |
| P.0 | the cy the | ys | Part ff. Other significant conditions | | | | | iven in Part | T. | | | | the causa of death? |
| | es that igned b | | Cr | ry) | | | | | | 10 | Yes 2□ No | 3 ☐ Prob | ebly 4 Unknown |
| Records, | G S E | d by | 4 / | fr) | Λ. | _ | | | | 24a Was | an autopsy | 24h We | re autopsy findings |
| Ö | need should | Completed | 7` \ | ssowe 1 | ME | SSUR | e | | | | rmed? | ava | illable prior to |
| ě | 80 CA | Ju | | | | | | | | | | of d | leath? |
| <u> </u> | Page Page | CO | | | | | | | | 10 | /as 2□No | 1 🗆 | Yas 2□ No |
| Division of Vital | Physician: The ribis certificate oral director, pag | Be | 25. Was cese referred to medical example ? | | | | | 26. Piac | e of Deeth | (Check only o | ne) | | |
| = | 0 0 | 9 | 1 Ves 2 No | Hospital: 1 ☐ Inpet | tient 2 🗆 E | ER/Outpatient | 3□ DOA O | ther: 4 N | ursing Hom | e 5 Resid | ience 8 🗆 Oth | er (Specify |) |
| 0 | ding Ph h. After th funera | | 27. Manner of Deeth 1 D Natural 5 ☐ Pending | 28e. Dete of in (Month, D | jury | 28b. Time of Injury | 28c. Inj | ury et | 28 | 3d. Describe I | now injury occur | red | |
| <u>ō</u> | Attending ir deeth. actor: After by the fune | atic | 1 Natural 5 Pending 2 Accident investigat | | | ,, | | Yes 2 | No | | | | |
| N S | or Attendi aftar deeth Director: A | ertification: | 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine | 289. Place of It | njury - At ho | me, farm, stre | et, fectory, office |) | 28 | | Street and Numb | per or Rural | Route Number, |
| | afte safte | Cert | 4 D Hornoide | building, e | etc." (Specify | | | | | City or Tov | vii, Siale) | | |
| | Hospital or Attens 24 hours aftar deet Funeral Director: staly filled in by the | | 29a. Certifier CertifyIng | Physician: To the best | t of my know | vledge, death | occurred et the | time, dete ar | nd place, ar | nd due to the | ceuse(s) end me | anner as st | ated. |
| | Ho Fu Fu | edicai | (Check only one) 2 Madical Ex | aminer: On the besis and manner s | of examineti | ion and/or inv | estigation, In my | opinion, dea | ath occurred | d et the time, | date and place, | end due to | the cause(s) |
| | To the Hospital or Attending Ph within 24 hours aftar deeth. To the Funeral Director: After th completaly filled in by the funeral | M | 29b. Signature and title of certifier | 1 . | | | 29c. Licer | nse number | | | 29d. Date signe | d (Month, I | Day, Year) |
| | | | 1 | In dan | m | | XIL | 1285 | _ | | 8-2 | Sec | 7 |
| / | | - | 20 Nome and address of | | door " | 00-) (T | | 203 | | | 0 - 2 | 8 / | 1, |
| / | (3) | | 30. Neme and address of person wh | | | | | | | | | | |
| | | | William D. Boyd 31. Date filed (Month, Day, Year) | | 253 | 65 Poi | nt Look | out Ro | pad, I | eonard | town, M | D_206 | 50 |
| | Sta Registr | | AUG 2 | Q 1997 | gnat | Lin Ran | dall | | | | | | |
| | negistr | aı | AUG & | 0 1001 | | | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene Q 7

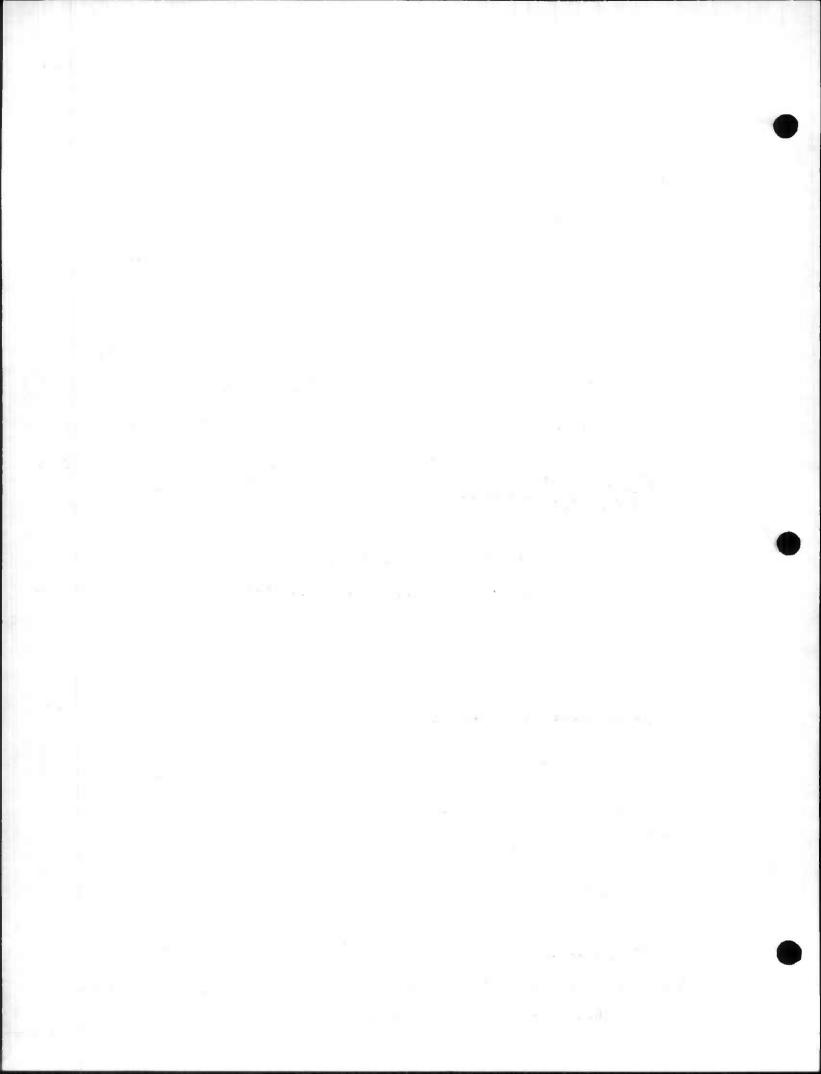
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| | | | | | | | Ce | rtificate | of i | Death | | | Reg. No. | 21 | 61 | 010 |
|------------|---|------------------|---|---------------|-------------------------------------|------------------------------|------------------|--------------------------------|----------------|------------------------------|--------------------|--------------------------------|-----------------|---|---|-----------------------------|
| П | Di i | | 1. Decedent's Neme (First, Mid | dle, Last) | | | | | | | | 2. Dete of De | eeth | V | | ime of Death |
| | Physic /Medi | | Billie Bren | da M | iarsh | all | | | | | | August | 28 ^y | 1997 | 8: | 03 PM |
| | Exami | | 4e. Fecliity Neme (If not instituti | on, give stre | et and nu | m <i>ber)</i> | | | - | b. City, Tow | vn, or Lo | cation of Deet | th 4c. 0 | County of De | eth | |
| | | | St. Mary's Ho | spital | | | | | I | Leonar | dtov | ٧n | St | . Mar | y's | |
| Г | Funeral | г | 5. Sociel Security Number | 6. Sex | | 7. Age (In yrs | . last birthday | | Yeer | If Under 2 Hours | 24 Hrs. Min. | 8. Dete of Bir (Month, Da | rth | 9. B | Birthplece (S Country) | State or Foreign |
| н | Director | | 246-60-4864 | 1 L M | 2 ■ F | 54 | Yrs. | | 30,3 | 710013 | | February | 24, 1 | 943 No | rth Ca | rolina |
| | put | | Usual Residence of Decedent 10e. Stete 10b. Count | | | 100.0 | ity, Town or L | acation | | | | | | | Land | 11.00.11.0 |
| | sho | 5 | | | | | | | | | | | | | | lde City Limits Yes 2 ■ No |
| | he N | ecto | | Mary' | 5 | | Califo | | | | | 1 | | | | 1103 2 110 |
| | filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23s or 28s-f show ent, the Medical Exeminer must be notified at | Funeral Director | 10e. Street end Number | 1 0 | | | | 10f. Zip C | | | | | 10g. Citize | en of Whet (| Country? | |
| | ath 23 | erai | 23364 Black 0 | | | | 1.0 | | 619 | | | | | ed St | | |
| | er de | nu | 11. Merifei Status | | Armed Fo | | U,S. 13. | Wes Deceder If Yes, specify | Cube | ispenic Orig en, Mexican, | In? (Spe Puerto | cify Yes or No Rican, etc.) | D- 14 | Rece - An Bleck, Wh | | en, |
| 20 | rs aft | by F | 1 Never Merried 2 Me 3 Widowed 4 Divorce | | 1 ☐ Yes If Yes, Giv Year or D | / 0 | | 1 ☐ Yes 2 | No | Specify: | | | 5 | pecify: | | |
| Ö | fura | pe | | nt's Educati | | B185. | 16a Daca | dent's Usuel (| Jacun | ation | | | 16h Vin | | hite | |
| 21215-0020 | in 72 | Completed | (Specify only high | est grade co | m <i>pleted)</i> | | (Give | kind of work | done d | during most | of worki | ng | TOD. KIT | d of Busines | sindustry | |
| 212 | with the | E | Elementary/Secondary (0-12) | | College (1 | -4or 5+) | | keeper | | | | | Tax | eran | | |
| | be filed tal Hyg d other event, | BeC | 17. Fether's Neme (First, Middle | , Last) | | | | меерег | | | 's Neme | (First, Middle | | | | |
| ar | should be filed and Mental Hygi marked other imatic event, i | To B | Walden Hatch | hett | | | | | | Ju | anit | a Rape | r | | | |
| Maryland | | - | 19e. informent's Neme/Relation | ship (Type, | Print) | | 19b. Meili | ng Address (S | Street | | | I Route Numb | | Town. State | . Zip Code) | |
| | nd 2 salth ar 27 is r trau | | Harley A. Marshall | , Husba | ind | | | | | | | ornia, M | | | | |
| Baltimore, | permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once. | | 20e. Method of Disposition | | | | Pleca of Dispo | sition (Name | of | 41 | T | Dete | 20c. Loc | atlon - City of | or Town, St | ete |
| E | Page ent c nt: # | | 1 ☐ Buriei 2 ☐ Cremetton 4 ☐ Connetion 5 ☐ Other (| | ovei from : | | ropolita | | | | 8_ | 30–1997 | Alevan | dria 1 | limini | |
| alt: | artm orta | | 21. Signatura of Augeral Service | ZLideolo | en | 1 | | 2. Name end | - 4 | se of Facility | , | | | | | |
| Ö | Depar Impor any Ir | | Much | 1 | 140 | (-) | | | | | Brin | sfield F | | | | |
| | | | Michael K. Bla | | | | ath. Do not en | 900 Hota | ywo of dvin | od Road | I, Le | onardtow | n, Mar | yland 2 | T | 279 oximate |
| | Physician | | 23e. Pert1. Enter the disease, of shock, or heart feilure. Lis | t only one c | euse on e | ech line. | | | , | 9, 00000 | | | | | Interv | el Between I end Death |
| 2 | /Medical | | Immediete Cause (Finel | | 1.1 | 1 " | | | ١ | 1. | | | | | | |
| | Examiner | | disease or condition resulting in deeth) | Θ | Н | epatti | or es e conse | epha | 10 | path | 7 | | | | Fiv | e days |
| | | ē | | | | | | | | | | | | | | |
| | eath certificate be executed attending physician and for use as the buriel-transit | Examiner | Convention lies and disease | b | | | or es e consec | | VE | 1 | | | | | + | |
| Ć, | certificate be executed rding physician and use as the buriel-transit | Exa | Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events | | | | | i ^ l | | 1-1 | | | | | | |
| 68760, | re be | cal | Cause (Diseese or Injury thet initieted events | c | G | as tro | or es e consec | +1091 | | bleec | 3100 | | | | + | |
| 9 | g ph | Medical | resulting in deeth) Last | | | 240101 | 0. 00 0 00.1000 | 100,100 017. | | | | | | | | |
| Box | n cer endin | | | d | | | | | | | | | | | 1 | |
| | death e atter | Physician/ | Pert II. Other significant conditi | ons confribu | utina to de | ath but not re | sulting in the u | nderiving caus | se div | en in Pert I | | 23b. Dld | tobacco u | ee contribu | te to the co | use of death? |
| P.0 | t the by th tech | hys | | | | | | | 30 g.v. | | | | | | | 4 Unknown |
| | es tha igned be de | by F | | | | | | | | | | | | | , | |
| Records, | - 0 D | 8 | | | | | | | | | | | en autops | y 24b | . Were auto | opsy findings |
| ပ္ထ | _ 00 | piet | | | | * | | | | | | pent | Jilled r | | | n of cause |
| æ | 0 - 0 | Completed | | | | | | | | | | 10 | Yes 2■ | No | 1□ Yes | |
| Vital | | Bec | 25. Was case referred to medical | al | | | | | - | 26 Place | of Death | (Check only | | | | |
| > | 5 00 | ToE | exeminer? 1 ☐ Yes 2 ■ No | Hosp | itel: 1 🗖 Ir | npatient 2 | ER/Outpetier | nt 3□ DOA | Othe | or: | | ne 5 Resi | | Other (Sc | necify) | |
| of | | | 27. Manner of Deeth | | 8a. Dete o | f Injury | 28b. Time of | | Injury Work | | | 8d. Describe | | | oury) | |
| 0 | ath. r: Ath | atio | 1 ■Neturei 5 □ Pendi 2 □ Accident invest | ng igetion | (MONII | h, Day Year) | Injury | M | | Yes 2 □ N | 0 | | | | | |
| Division | Attending I er death. ector: After by the fune | E C | 3 Sulcide 6 Could determ | | 8e. Pleca | of Injury - At h | ome, farm, str | eet, fectory, o | ffice | | 2 | 8f. Location (| Street and | Number or I | Rural Route | Number, |
| Ö | 이 분 등 드 | Certification: | 4 LI HOMICIGE | | buildin | ig, etc. (Speci | <i>'Y)</i> | | | | | City or To | wn, State) | | | |
| | To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by | | 29a. Certifier 1 Certifyi | ng Physicia | n: To the | best of my kno | owledge, death | occurred et t | he tim | e, date end | plece, e | nd due to the | cause(s) a | nd manner | as stated. | |
| | n 24 n 24 ne Fu | Medical | (Check only 2 Medical one) | Examiner: | On the ba end mann | sis of examine er steted. | etlon end/or in | estigetion, in | my or | olnion, deeth | occurre | d et the time, | date end p | lace, and du | ue to the ca | use(s) |
| | within To the comple | ž | 29b. Signature and title of certific | 5 | (Q., | | | 29c. L | icense | number | | | 29d. Dete | signed (Moi | nth, Day, Yo | ear) |
| | | | 1 | Ou | el | 500 | 00 | , 1 | 50 | 0044 | | | Ana | 29, | 1997 | |
| | (0) | 1 | 30. Neme and address of person | who comple | eted caus | of deeth (Ite | n 23e) (Type, | March 1 | | | | | J | - , , | 1 | |
| (| | | MOHAMMAD RAHM | | | | IP J. | | EDT | CAT. C | TR. | HOLLYW | M . (100 | 0.206 | 36 | |
| | Sta | te | 31. Dete filed (Month, Day, Year |) | 32. Re | aistrer's Sian | eture | | ـد نـد | ULLE U. | - 110 | aa V AdAd A 71 ' | 000,11 | | | |
| | Registr | | VIIC | 29 10 | 97 | deli Me | wilson Ro | reall | | | | | | | | |
| DHI | MH 16 Ray 6/95 | 5 | HUU | 13 | 31 | 1 | | | | | | | | | | |

BILLIE BRENDA MARSHALL

State of Maryland / Department of Health and Mental Hygiene 07 07071

| | | | | | • | Certif | ficate of | | R | eg. No. | 1 6 | . 1011 |
|----------|--|----------------|---|---|---------------------------------|-----------------------------|-----------------------------------|---|--|----------------------------------|----------------------------|--|
| | | | 1. Decedent's Name (First, Middle, La | est) | | | | | 2. Dete of Deet | th | W. | 3. Time of Deeth |
| | Physic | | AGNES LORR | AINE MOO | RE | | | | Month (Mul) | 25 I | 697 | 23 55 |
| Š, | /Medi Examir | | 4e. Fecility Neme (If not institution, gir | | | | | 4b. City, Town, or L | | 4c. County | of Death | 0- |
| | | | WASHINGTON COUNT | Y HOSPITAL | | | | HAGERST | OLIN | LJ | ASHIN | TON |
| Н | Funeral | | | | e (In yrs. lest bir | | Under 1 Year | if Under 24 Hrs. | 8. Date of Birth | | | |
| e . | Director | | 215-26-1279 Usuel Residence of Decedent | 1□M 2[Q]F | 67 | Yrs. M | onths Deys | Hours Min. | FEB. 5, | 1930 | MA] | lece (Stete or Foreign try) RYLAND |
| | iand m | | 10a. State 10b. County | | 10c. City, Tow | n or Loceti | on | | | | 10 | Od. Inside City Limits |
| | f sh | ō | MADNI AND LIACITA | CONON | | | | A CEDE COMOL BY | | | | 1 ☑ Yes 2 ☐ No |
| | 1he 1 | Directo | MARYLAND WASHIN 10e. Street end Number | GION | | | III 10f. Zip Code | AGERSTOWN | 1 | 0g. Citizen of \ | Affron Count | ** |
| | with a se | ₫ | | | | | | 04=10 | , | | | ryr |
| | eath s 23 | Funeral | 522 WEST CHURCH | 12. Wes Decedent E | Tues in 11 C | 10 140- | | 21740 | | U.S. | .A. a - America | |
| | ther free | Ë | 1 Never Married 2 Married | Armed Forces? | | If Ye | s, specify Cub | Hispenic Origin? (Sp an, Mexican, Puerto | Rican, etc.) | | ck, White, e | |
| 20 | be filed within 72 hours after death with the Meryland the Hyglene. d other than "natural", or flems 23a or 28a-f show event, the Medical Exemines must be notified at | by F | 3 ₩ Widowed 4 Divorcad | 1 ☐ Yes 2 ☑ N If Yes, Give Yeer or Dates: | 10 | 1 🗆 | Yes 2X No | Specify: | | Specify | y: x 77 7 | TON |
| 5-0020 | hou | P | 15. Decedent's E | | 16a | Decedent | 's Usuel Occu | netion | | 16b. Kind of Bi | | ITE |
| 215 | n n | Completed | (Specify only highest gr | ede completed) | | (Give kind | d of work done NOT use retire | during most of work | ring | TOD. KING OF DI | 33110331110 | dony |
| 212 | with iena. than | E | Elementery/Secondery (0-12) | College (1-4or 5 | +) | | ITRESS | , | | PUBLIC | DECT | ידיוא א כדו זא |
| | 2 should be filed and Mentel Hygi is marked other aumatic event, I | Be C | 17. Fether's Neme (First, Middle, Last |) | | *17. | LILLION | 18. Mother's Nam | | | | TOMAINT |
| aryland | Mentel Mentel of arked of artic eve | To B | RALPH EDWARD SHA | NK | | | | ROSEY M | AY SMITH | | | |
| 3 | 2 should and Men is marks | - | 19e. Informent's Neme/Reletionship (| | 19b | . Melling A | ddress (Stree | end Number or Rus | | | Stete. Zip | Code) |
| Σ | end 2 palith a n 27 is | | HOWARD E. MOORE/ | SOM | | | | AVENUE, | | | | |
| e, | s 1 and 2 should f Haalth and Mer tem 27 is marks other traumatic | | 20e. Method of Disposition | DOIN | 20b. Pleca of | Disposition | on (Neme of | ! | | 20c. Location - | | |
| more, | 60 0 | | 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Special | | | | ory or other ple | - | | | | |
| = | permit. Pag Department Important: if any injury o | | 21. Signeture of Junerel Service Line | | LCEDAR | | MEMOR eme end Addre | IAL PARK8 | [28/97]] | HAGERST | OWN, | MARYLAND |
| Bai | Depariment Important In Price. | | 120. | 1 | 1. Dean | | | · · | 7606 01d | Nation | al Pi | ke |
| _ | | | Vaul M.K. | Car . | | | | RAL HOME | Boonsbor | o, Mary | land | 21713 |
| | | | 23e. Part1. Enter the diseese, or com shock, or heart feilure. List only | plicetions that caused one cause on each lin | the deeth. Do r | not enter th | ne mode of dyl | ng, such es cardiec | or respiretory arre | est, | | Approximete Interval Between |
| | Physician /Medical | | ACCOUNTS OF THE CO. | | | | | | | | | Onset end Deeth |
| ê. | Examiner | | Immediate Ceuse (Finel disease or condition resulting in deeth) | e. ALUTE | MYO | CHAD | 116 | NEHRCT | 1000 | | 5 | UDDEN |
| | | <u></u> | rossining in doorin) | | Due to (or es e | consequen | ice of): | • | | | 1 | |
| | led isit | Examiner | | b. ARTERIO | SCLERO | TIC | HENAT | DISER | SE | | ر | JNKNOUN |
| | ceta be axecuted physician end s the buriel-transit | xan | Sequentially list conditions, if env. leeding to immediate | | Due to (or es e | consequen | ca of): | | | | | |
| 9 | be a ician burie | | Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury | C | | | | | | | i | |
| 68760 | certificeta be axecuted Iding physician end Ise as the buriel-transit | edical | thet initiated events resulting in deeth) Lest | | Due to (or es e o | consequen | ca of): | | | | 1 | |
| ŏ | ding ph | 2 | | d | | | | | | | | |
| g | ath for t | ian | | | | | | | | | į | |
| o. | 0 0 0 | Physician/ | Pert il. Other significent conditione o | contributing to death bu | t not resulting in | the under | rlyIng cause gi | ven in Pert 1. | 23b. Did to | bacco use co | ntribute to | the cause of death? |
| 1 | law requiras that the as been signed by the a 2 should be detache | | DIMBETES MELL | ודעב דעם | E II | | | | 1□ Ye | s 2 No | 3 Prob | ably 4 Hinknown |
| Records, | signed I | 1 by | | | - | | | | | | Odb We | an authorizan Almadia a |
| Ö | v require been signal | Completed | | | | | | | 24e. Wes er perform | n eutopsy ned? | ave | re autopsy findings illeble prior to npietion of cause |
| 9 | law a 2 s | ldu | | | | | | | | | of d | leeth? |
| | The law | S | | | | | | | 1□ Ye | s 2 100 | 1 🗆 | Yes 2□ No |
| VItal | ysicism: The second of sec | Be | 25. Wes case referred to medical exeminer? | | | | | 26. Plece of Deet | | | | |
| 5 | physic this c | 10 1 | 1 Yes 2 No | | nt 2 ER/Ou | tpatient 3 | 3□ DOA OI | ner: 4 ☐ Nursing Ho | ome 5 - Reside | nce 8 Oth | er (Specify |) |
| | ding P. h. After t funera | on: | 27. Menner of Deeth 1 ☑Naturel 5 ☐ Pending | 28e. Dete of Injur (Month, Dey | y Year) 28b. 1 | Time of njury | 28c. Inju Wo | ry et rk? | 28d. Describe ho | | | |
| S | Attending Physician: or deeth. ector: After this certific by the funeral director, | cati | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b | NONE | 5 | | M 1□ | Yes 2 No | | | | |
| UIVISION | or Attendeter desti | Certification: | 3 Suicide 6 Could not be determined | | ry - At home, fe . (Specify) | rm, street, | fectory, offica | | 28f. Location (St. City or Town | | er or Rurel | Route Number, |
| _ | ital c | | | | | | | | | | | |
| | To the Hospital within 24 hours a To the Funeral C completely filled | edical | 29e. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar | nysician: To the best of niner: On the bests of end manner star | examinetion en | , deeth occ d/or investi | curred et the ti gation, in my | me, dete end plece, opinion, deeth occur | end due to the ca red et the time, da | ause(s) and me ate and place, | enner as ste end due to | eted. the cause(s) |
| | Nithin Fo the | Me | 29b. Signature end title of certifier | | | | 29c. Licens | se number | 25 | 9d. Dete signe | d (Month, D | Dey, Year) |
| | . 2 - 0 | | B. ness | | | | 700 | 040 | | 28-20 | _ 4 2 | |
| , | | | 30. Neme end eddress of person who | completed rause of do | eth (Itam 23a) | Type Dri- | | 770 | - | 0-26 | -1/ | |
| | | | • | | | | | = 44/- | 10010.00 | 40. 3 | 1 | |
| | Sta | te | 31. Dete filed (Month, Dey, Yeer) | | r's Signeture | , wo of | DAING | E) HAGE | SIUWA | 11/ | 417 | _ |
| | Registr | | AUG 27 | 1997 | r's Signeture | on Br | della | | | | | |



| | | | | State of Mary | land / | | rtment o | | | Mental H | ygiene 9 | 7 27 | 072 |
|---------------------|--|----------------|---|--|---------------------|--------------------------|----------------------------------|-------------------|---------------------------------------|--|--|--------------------------------------|-----------------------------|
| | Physici | | Decedent's Neme (First, Middla, Last | | lward | l Ma | rtin | | | 2. Dete of D Month Augus | Peeth Dey | Year | Time of Death |
| | /Medi Examir | | 4e. Fecliity Nema (If not Institution, giva | street and number) | | | | 4t | o. City, Town, or | | the same of the sa | | 00 A.M. |
| | EAGITIII. | | 13811 Weaver Ave. | | | | | | Maugans | ville | Was | hington | |
| | Funeral | | Social Security Number 6. Se | | yrs. lest | birthday) | If Undar 1 \ | | If Undar 24 Hrs Hours Min | 6. Deta of B | | | Stata or Foreign |
| н | Director | | None / | (M 2□ F | | Yrs. | 1 1 | 2 | TIOUIS INIII | July | 12, 1997 | Maryla | nd |
| | pue * | | Usuel Residence of Decedent 10a. State 10b. County | 10 | c City To | own or Loc | eation | | | | | 10d In | side City Limits |
| | Aenyte f aho | 0 | MD. Washingt | | | ansv | | | | | | | Yes 2 No |
| | the 1 | Director | 10e. Street end Number | | | | 10f. Zip Co | ode | | | 10g. Citizen of | What Country? | |
| | 3a or | ā | 13811 Weaver Ave | | | | | 767 | | | U.S.A. | with obtaining i | |
| | 2 should be filed within 72 hours efter deeth with the Maryland and Mental Hyglene. Is marked other than "naturel", or farms 23s or 28s-f show aumatic event, the Medical Examiner must be recitied at | Funeral | 11. Merital Stetus | 12. Was Dacedent Ever | In U,S. | 13. V | | | spenic Origin? (S n, Mexican, Pue | Specify Yas or N | | ce - Amarican Inc | tien, |
| 0 | or its | | 1 Navar Married 2 Merried | Armed Forcas? | | | | | | to Ricen, etc.) | | ck, White, etc. | |
| 02 | ours (| by | 3 Wildowed 4 Divorced | If Yes, Give Year or Detas: | | 1 | ☐ Yas 2 🔏 | No | Specify: | | Specif | White | |
| Maryland 21215-0020 | 72 h netu dicel | Completed | 15. Decedent's Edu (Specify only highast gred | | 16 | (Give I | ent's Usual C | done di | uring most of wo | rkina | 18b. Kind of B | usiness/Industry | |
| 12 | hen. | mpl | Elementery/Secondery (0-12) | Collage (1-4or 5+) | | life. D | O NOT use / | ratired) | | | | | |
| N | Hygie ther t | ပိ | 17. Fathar's Nema (First, Middle, Last) | | | ! | None | | 19 Mother's No | ma /First Middl | No. | | |
| an | ad be and of | Be | Michael R. Mart | in | | | | | | nie S. I | | 10) | |
| 2 | should Me mark | 2 | 19a. Informant's Neme/Reletionship (T) | | 1 | 9h Meilin | n Address (S | Street a | | | ber, City or Town, | State Zin Code | .) |
| 2 | end 2 and 2 and 2 and 27 le | | Michael R. Mart | | | | | | | | 8 Maugans | | |
| ē, | f Hee f Hee ftem | | 20a. Method of Disposition | 2 | Oh Place | of Disnos | ition /Nome | of | Reiff's | Dete | | City or Town, S | |
| Baltimore, | Peges nent of i nrt: If ite iry or o | | 1 Burlal 2 Cremetion 3 F 4 Donetion 5 Other (Specify) | lemovel from Stete | | | | | metery | 8/25/07 | Cearfo | cc Md | |
| a | 고투현증 | | 21. Signeture of Funerei Sarvice Licens | | CIIIO | 22. | Neme end A | Address | s of Facility | | | 33, Mu. | |
| m | Depar Impor any ir | | H. Martin C | Remeimo | ナ | | | | nd Són | | Home | | |
| | 1 TE- 1 | Т | 23e. Pert1. Enter the disease, or compl shock, or heert feilure. List only or | cations that caused the | death. D | o not enta | r the moda o | S U I | e, Pa. , such as cardia | 1 / ZZS c or respiretory | errest, | Appr | oximate |
| | Physician | | SHOCK, OF HEER FEMALES. LIST ONly OF | le ceuse on each line. | | | | | | | | Onse | vel Between at and Death |
| | /Medical | | Immediate Cause (Final disaasa or condition | Respirat | ory | Failu | ire | | | | | HK | 25 |
| | Examiner | | resulting in deeth) | Due | to (or es | a consequ | uence of): | | | | | | |
| | D # | Examiner | | Werdnig- | Hoff | mann | Syndro | ome | | | | we | eks |
| | icate be executed physician end s the buriel-transit | хап | Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury | Due | to (or es | e consequ | uence of): | | | | | | |
| 8/60, | sician burie | dical E | Cause (Disease or Injury that initiated events | | | × | | | | | | i | |
| 2 | ificate p phy ss the | 0 | resulting In death) Lest | Due | to (or es | e consequ | ence of): | | | | | | |
| ROX | requires that the death certificate be executed een signed by the attending physician and hould be deteched for use as the buriel-transit | Physician/M | | 1 | | | | | | | | | |
| | death | sicie | Pert II. Other significant conditions con | stributing to death but no | t resulting | g in the un | derlying ceus | sa give | n In Pert I. | 23b. Die | tobacco use co | ntribute to the | ause of death? |
| r Ö | res that the de signed by the a be deteched t | Phy | | | | | | | | 10 | Yes 200 No | 3 Probably | 4 Unknowr |
| | es the | by | | | | _ | | | | | | | |
| Hecords, | v require been si should I | Completed | | | | | | | | | s en eutopsy formed? | available | |
| ၁ | | uple | | | | | | | | | | of death | on of ceusa ? |
| | sician: The lew certificate hes b lirector, page 2 s | | | | | | | | | 10 | Yes 2 No | 1 🗆 Yes | 2□ No |
| VITal | Physician: this certific ral director, | Be | 25. Wes cese referred to medicel examiner? | lospitel: | | | | Otho | | eth (Check only | one) | | |
| ō | his alo | - To | 1 ☐ Yas 2 ☑ No 27. Menner of Deeth | 1 L Inpatient | | Outpatient Time of | | Othe | 4 Li Nursing | | how injury occur | | |
| 0 | ding h. After funer | tlon | 1 Neturel 5 Pending | 28a. Dete of Injury (Month, Day Yea | ar) 200 | Injury | М 250. | Injury Work | ? 'es 2∐No | 20g. Describe | now injury occur | 190 | |
| DIVISION | of or Attending P safer death. I Director: After to d in by the funer | fica | 3 Suicide 6 Could not be | 28e. Plece of Injury - | At home, | ferm, stre | | | | 28f. Location | (Street and Numb | per or Rural Rou | te Number, |
| 5 | s afte | Certification: | 4 Homicide | building, etc. (S | pecify) | | 1125 | | | City or To | own, Stete) | | |
| | To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by | edical | 29e. Certifier (Check only one) 1 | sicien: To the best of my ner: On the bests of exar end menner steted. | knowled minetion | ige, deeth end/or inv | occurred et ti estigetion, in | ha tima my opi | a, date and plece Inion, deeth occ | e, end due to the urred at the time | e ceusa(s) and mo , dete and plece, | enner as steted. end due to the o | ause(s) |
| | Withir To the | Me | 29b. Signature and title of dentiller | 000 | | | 29c. Li | icanse | number | | 29d. Data signe | d (Month, Day, | (ear) |
| | | | · CXMW | do las | | | | Ι | 11266 | | August 2 | 5, 1997 | |
| • | | | 30. Neme and address of person who co | mpleted ceuse of deeth | (Item 23s | a) (Type, F | Print) | | | | | | |
| | | | Howard N. Weeks, M. | D., 580 Non | ther | n_Av | enue, | Hag | erstown | , Maryl | and 2174 | 2 | |

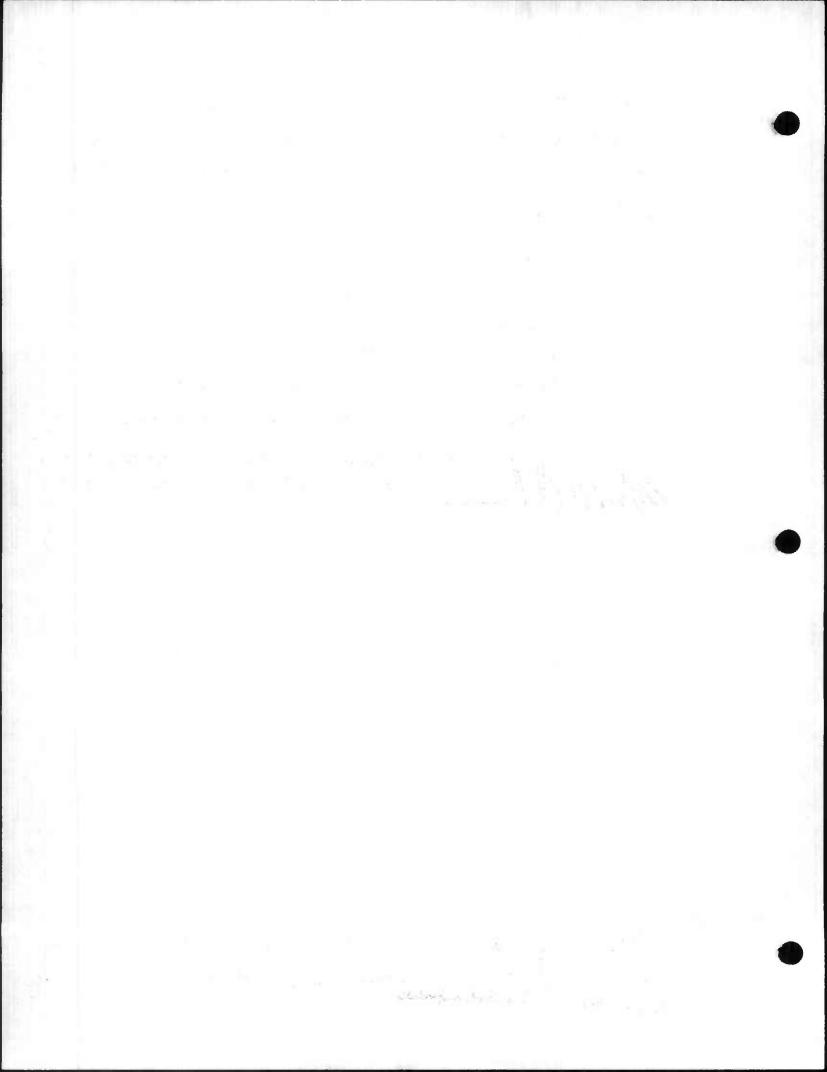
Registrar DHMH 16 Rev 6/95

State

31. Dete filed (Month, Dey, Year) AUG .2 6 1997

State of Maryland / Department of Health and Mental Hygiene 97 27073

| | | | | | | | | | _ | | | Reg. No. | | | |
|--|--|---|--|--|--|---|--|--|--|---|--|--|---|--|--|
| Physic | | 1. Decedent's Neme (First, Mid Hilda May | die, Last) Mose | | | | | | | | 2. Date of D Month AUGUS | Day | 13 | 9 9 7 | 3. Time of Death 2:40 pt |
| /Med Exami | | 4a. Facility Name (If not instituti | on, give street an | d number) | | | | 41 | b. City, To | own, or Lo | ocation of Dea | | County of | f Death | |
| | | Colton Villa | Nursing | Home | | | | | Hag | erst | own | | Wash | ning | ton |
| Funeral | Г | 5. Sociel Security Number | 6. Sax | | e (In yrs. last b | | If Under 1 Yo Months De | | If Under Hours | | | irth | | 9. Birthpl | lece (Stata or Foraio |
| Director | | 217-10-2877 | 1□ M 2Ž | F | 102 | Yrs. | WOUTHIS De | ys | riours | IVIII I. | 8. Data of B NOV • 4 | ,1894 | | Mai | ry land |
| and | | Usuel Rasidence of Decedent 10a. State 10b. Count | ty | | 10c. City, Toy | wn or Loc | cation | | | | | | | 10 | 0d. Inside City Limits |
| Maryl f sho | ō | | ington | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | arpsbur | חים | | | | | | | 1 ☐ Yes 2 🕅 No |
| 28a | Director | 10e. Street end Number | 1119 0011 | | | 3110 | 10f. Zip Cod | _ | | | | 10g. Citiz | on of Mile | not Count | |
| with with | ā | 17370 Shepher | detown D | iko | | | | 78 | 2 | | | Tog. Oniz | | | ll y ! |
| Jeath Fre 2 | Funeral | 11. Marital Stetus | 12. Wes | Decedent I | Ever in U,S. | 13. W | | - | | igin? (Sp | ecify Yes or N | 10- 1- | US/ | | an Indien, |
| or he | | 1 Never Married 2 Ma | rried 1 TY | d Forces? | No | | Vas Decedent Yes, specify 0 | | | | Rican, etc.) | | Black, | , White, e | etc. |
| 172 hours after death with the Maryland "natural", or flems 23a or 28a-f show folical Examiner must be notified at | by | 3 Nidowed 4 Divorce | d If Yes | s, Give or Detes: | | 1 | ☐ Yes 2)(☐ | No | Specify: | | | 5 | Specify: | Whit | te |
| n 72 ho "netur | Completed | 15. Decede (Specify only high | nt's Education | ted) | 166 | Decede | ent's Usuel Oc | cupe | tion | et of work | ina | 16b. Kin | d of Busi | iness/Ind | iustry |
| 를 그를 | npie | Elemantary/Secondary (0-12) | | ga (1-4or 5 | i+) | life. D | kind of work do OO NOT use ra | tired) | uring into | or work | m g | | | | |
| filed with Hygiene ther thai | | 8 | | | | | Assemb | | | | | | | ft Ma | anu. |
| d fai | Be | 17. Father's Neme (First, Middle | | | | | | | | | (First, Middl | | Su <i>ma</i> me) |) | |
| should that marked | 2 | | n Delaun | | | | | | | | e Brash | | | | |
| 0 0 0 | | 19e. Informent's Name/Reletion Joannette Rohr | | | ughter 19 | | g Address (Str 370 She | | | | | | | | |
| Heell m 2 | | 20e. Method of Disposition | CI KIEUZ | CI / I/a | | | ition (Name o | | erus | COMIT | Dete | | - | , | D 21782 wn, Stete |
| 200 | | 1 Burial 2 Cremation | | rom Stete | cemete | ery, crema | atory or othar | placa | i) | | | | | | |
| permit. Page Department of Important: If any Injury or pince. | | 4 Donetion 5 Other (| 11 1 | | Mt. Vi | | Cemeter | | | | -27-97 | | | | Maryland |
| permit. Page Department of Important: If eny Injury or once. | | 21. Signature of Forgaral Service | 171 | | | 03 | Sporne | FU | nera | Hor | ne 425 | S. Co iamsp | noco | ochea | ague St. |
| | | 23a. Part Enty the disaese, o | - (right | ~ | | | | | | | 19 | Idilisu |)() ['] | . ITD | 21795 |
| /Medical Examiner | ner | Immediate Causa (Final disasse or condition resulting in death) | e. A | T1+1 | ERO. Due to (or es a | SC F | -T=RO | TIC | , C1 | 710 | or respiratory | arrast, | DIST | BASIS | Approximete Intervel Between Onset and Death |
| cate be executed physician and the burial-transit | dicai Examiner | Immediete Ceusa (Finel disaese or condition | e. Ric | THI 2HT | ERO. | SC F consequence consequence L | Jence of): NOVE Jence of): VASC | TIC Hs | CUL | tro ar | or respiratory | arrast, CULAR DE N | DIST | BASIS | Approximete Intervel Between Onset and Death |
| certificate be executed ming physician and use es the burial-transit | n/Medical | Immediete Ceusa (Finel disaese or condition resulting in death) Sequentielly list conditions, if eny, leeding to immediete causa. Enter Underlying Cause (Disease or Injury that initieted events | e. Ric | THI 2HT | Due to (or es a COA Due to (or as e | SC F consequence consequence L | Jence of): NOVE Jence of): VASC | TIC Hs | CUL | tro ar | or respiratory 10VAS | arrast, CULAR DE N | DIST | BASIS | Approximete Intervel Between Onset and Death |
| certificate be executed carding physician and case es the burial-transit | n/Medical | Immediete Ceusa (Finel disaese or condition resulting in death) Sequentielly list conditions, if eny, leeding to immediete causa. Enter Underlying Cause (Disease or Injury that initieted events | b. R16 | THI 2HT | Due to (or as a Due to (or as a | SC F consequence Consequence Consequence | Lence of): V AS (Jance of): | Dic Hs | CUL. | tro ar | PCE I | CULAR CULAR DEN EIASE | DIST | PASIS | Approximete Intervel Between Onset and Death 24FAR 24BARS 2 mon 16 the cause of death |
| certificate be executed the company of the company | Physician/Medical | Immediate Ceusa (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest | e. Rica d | THI 2HT | Due to (or es a COR Due to (or as e PHERA Due to (or as a | SC F consequence Consequence Consequence | Lence of): V AS (Jance of): | Dic Hs | CUL. | tro ar | PCE 1 DIST | CULAR CULAR DEN EIASE | D(St | PASTS | Approximate Intervel Between Onset and Death 24FAR 24BARS 2 mon 16 the cause of death |
| sw requires that the death certificate be executed as been signed by the ettending physician and should be detached for use es the bunial-transit | by Physician/Medical | Immediate Ceusa (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest | e. Rica d | THI 2HT | Due to (or es a COR Due to (or as e PHERA Due to (or as a | SC F consequence Consequence Consequence | Lence of): V AS (Jance of): | Dic Hs | CUL. | tro ar | PCE I DIST | CUMAR DEN EVASE | D(St | ribute to | Approximete Intervel Between Onset and Death 24FAR 24FAR 24FAR 24FAR 15 16 16 16 16 16 16 16 16 16 |
| tw requires that the death certificate be executed by the ettending physician and be a should be detached for use es the bunal-transit as a second by the ettending physician and bunal-transit as a second by the ettendent of the second be detached for use es the bunal-transit. | by Physician/Medical | Immediate Ceusa (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest | e. Rica d | THI 2HT | Due to (or es a COR Due to (or as e PHERA Due to (or as a | SC F consequence Consequence Consequence | Lence of): V AS (Jance of): | Dic Hs | CUL. | tro ar | DIST | CULAR CULAR DEN Lobacco u Ves 2 s an autops ormed? | D(St | ribute to 3 Prob | Approximete Intervel Between Onset and Death Onset and Death 2 4 FAR 2 4 BARS 2 Mon 16 the cause of death ably 4 Unknown a autopsy findings illable prior to applation of causa laath? |
| The law requires that the death certificate be executed by the ettending physician and page 2 should be detached for use as the bunal-transit on the page 2 should be detached for use as the bunal-transit of the page 2 should be detached for use as the bunal-transit of the page 2 should be detached for use as the bunal-transit of the page 2 should be detached for use as the bunal-transit of the page 2 should be detached for use as the bunal-transit of the page 2 should be detached for use as the bunal-transit of the page 2 should be detached for use as the bunal-transit of the page 2 should be detached for use as the bunal-transit of the page 2 should be detached for use as the bunal-transit of the page 2 should be detached for use as the bunal-transit of the page 2 should be detached for use as the bunal-transit of the page 2 should be detached for use as the bunal-transit of the page 2 should be detached for use as the bunal-transit of the page 3 should be detached for use as the bunal-transit of the page 3 should be detached for use as the bunal-transit of the page 3 should be detached for use as the bunal-transit of the page 3 should be detached for use as the bunal-transit of the page 3 should be a should b | Completed by Physician/Medical | Immediate Ceusa (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Pert II. Other significent conditions. | e. A b. R16 c. N6 d. | THI 2HT | Due to (or es a COR Due to (or as e PHERA Due to (or as a | SC F consequence Consequence Consequence | Lence of): V AS (Jance of): | Dic S | CV L LAI | AR R | DIST | CUMAR CU | D(St | ribute to 3 Prob | Approximete Intervel Between Onset and Death Onset on Its Onset on I |
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State of Maryland / Department of Health and Mental Hygiene 97 27074

| | | | | Cer | tificate of | Death | R | eg. No. | | |
|-------------|--|-----------------|--|-----------------------------|---|---|------------------------------------|----------------------------|---|-------|
| | | | Decedent's Name (First, Middia, Last) | 17 | | | 2. Date of Deat | h | 3. Time of Deat | th |
| | Physici /Medi | | Thelma C. Marsh | | | | August | 14, 19 | 997 15:03 | |
| | Examir | | 4a. Facility Name (If not institution, giva street and number) | | | 4b. City, Town, or I | | 4c. County of | | |
| | | | Kent & Queen Annes Hospit | al | | Chester | town | Ke | ent | |
| | Funeral | | | rs. last birthday) | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, | Veerl | 9. Birthplaca (Stete or Ford Country) | aign |
| | Director | | 216-24-5390 1□ M 2CNF 68 Usual Residence of Decedent | Yrs. | Widnitis Days | Flours 10mm. | January 1 | 1, 1929 N | Maryland | |
| | should be filed within 72 hours after death with the Maryland nd Mental Hygiene. I merked other than "natural", or itema 23a or 28e-f show umatic event, the Medical Exercines must be notified at | Director | Maryland Queen Annes | City, Town or Loo Cheste | | | | | 10d. Inside City Lin 1 ☐ Yes 2€ | |
| | with the or 2 | Dire | 10e. Street and Number | | 10f. Zip Code | .00 | 1 | 0g. Citizen of W | | |
| | eath 23 | era | 108 Longfellow Drive 11. Marital Status 12. Was Decedent Ever In | II S 12 V | 216 | | anaihi Van ar Na | | S.A. | |
| 020 | is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. It was a second to the than "nature!", or item 23 or 28e-f show than 27 is merked other than "nature!", or item as 23 or 28e-f show other traumatic event, ma Medical Examples must be nothered as | by Funeral | 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: | If | f Yes, specify Cub | dispanic Origin? (S an, Mexican, Puert Specify: | o Rican, etc.) | | k, White, etc. | |
| 21215-0020 | on 72 ho | Completed | 15. Decedent's Education (Specify only highest grada complated) | 16a. Deced (Give I | lent's Usual Occup kind of work dona | pation during most of wor d) | king | 16b. Kind of Bus | siness/industry | |
| 212 | with ene. | E C | Elementary/Secondary (0-12) College (1-4or 5+) | | ashier | 0) | 1 | Optoil. | Grocery St | + ^ * |
| 0 | filled Hygir ther | Ö | 17. Father's Name (First, Middia, Last) | | asinter | 18. Mother's Nan | ne (First, Middle, M | | | LOI |
| an | d be ental ced o | To Be | Michael Quasney | | | | Lulie (| | | |
| Maryland | shoul meri | F | 19e. Informent's Neme/Relationship (Type, Print) | 19b. Mailin | a Address (Street | | | | Stata, Zip Coda)2162(| 0 |
| , M | and 2 baith a n 27 is | | Eugene T. Marsh/Husband | 108 | Longfel | | | | own, Maryla | |
| nore | Pages 1 nent of H int: If itar ury or oth | | 1 Durial 2 □ Cremation 3 □ Removal from State | - | natory or other pie | | | | City or Town, State | |
| Baltimore, | permit. Pages Department of Important: If it any injury or o | | 4 ☐ Donation 5 ☐ Other (Spacity) 21. Signature of Fuperal Service Licensee | | | | | | k, Maryland cal Home, P.A | ٨ |
| n | 20E 5 8 | | Kirk of Hulferter | Ch | estertow | m, Maryla | and 21620 |), 130 S | Speer Road | 1. |
| | | | 23a. Part1. Enter the disease, or complications that caused the de shock, or heart feilure. List only one paye on each line. | ath. Do not ente | er the mode of dylr | ng, such as cardiac | or respiratory arre | est, | Approximate Intervel Between | |
| | Physician | | 01 | | 01 | / | | | Onset and Death | 1 |
| | /Medical Examiner | | Immediate Cause (Final disease or condition | ronary | Smb | 0/45 | | | | |
| | LAGITITICI | L. | resulting in death) a. Due to | (or as a copyequ | uence of): | | | | | |
| | ed sit | ine | b | | | | | | | |
| o î | ertificate be executed Jing physician and se as the burial-transit | edical Examiner | if any, leading to immediate cause. Enter Underlying | (or as a consequ | uence of): | | | | | |
| 68/PU, | ate be hysici the bu | Jical | Cause (Diseese or Injury that Initiated events positing in death) Last Due to | (or as a consequ | uence of): | | | | | |
| OX O | ding ding | 3 | d | | | | | | | |
| 0 | death e atter | Icla | Part II. Other significant conditions contributing to death but not re | esulting in the un | deriving cause gis | en in Part I | 23h Did to | hacco ties cont | tributa to the cause of dea | eth? |
| 7. O | by th | Physician | | ooding in the dir | deliying cades give | ron at rail t. | 1 🗆 Ye | | 3 Probably 4 Unkn | |
| S, | Se G e | l by | | | | | | | | |
| Hecord | 77 (2) | Completed | | | | | 24a. Was a | n autopsy ned? | 24b. Were autopsy finding available prior to completion of cause of death? | |
| | 0 - 0 | шо | | | | | 1 🗆 Ye | s 2 No | 1 ☐ Yes 2 ☐ No | |
| VItal | | Be C | 25. Was case referred to medical | | | 26 Place of Dea | th (Check only on | | | |
| | ysick s cer direc | 0 | examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 | ☐ ER/Outpatient | 3 DOA OIT | nor: | ome 5 Reside | | r (Specify) | |
| 0 | Attending Physician: or death. ector: After this certific by the funeral director, | n: T | 27. Manner of Death 28a. Dete of Injury | 28b. Time of | 28c. Injur Wor | | 28d. Describe ho | | | - |
| 5 | tendin leath. tor: Aff the fur | atio | 1 Maturel 5 ☐ Pending (Month, Dey Year) 2 ☐ Accident investigation | Injury | | Yes 2 □ No | | | | |
| DIVISION OF | 3 4 4 6 | Certification: | 3 Suicide 6 Could not be determined 28e. Plece of fnjury - At building, etc. (Special Could not be determined 5) | home, farm, stre | eet, factory, office | | 28f. Location (St. City or Town | reet end Numbe , Stata) | or or Aural Aouta Number, | |
| | To the Hospital or within 24 hours after To the Funeral Dir completely filled in | edical Co | 29a. Certifier (Check only 2 Madical Exeminar: On the basis of examinarial e | nowledge, death | occurred at the tir | me, dete and place | , and due to the ca | use(s) and man | ner as stated. | |
| | the I the I the I | Med | and manner stated. | | | | | | | |
| | 5 ¥ 5 00 | | 29b. Signature and title of certifier | | 29c. Licens | 190mun e | 29 | ou. Date signed | (Month, Day, Year) | |
| | | 10 | Joseph III. allen | | 13 | 8972 | | 8/15/ | 47 | |
| | | | 30. Neme and eddress of person who completed cause of deeth (It | em 23a) (Type, F | Print) Roll | edo 1 | 1. A | Oline | ore Md 212 | ric |
| P | Sta | te | 31. Date filed (Month, Day, Yaar) 32. Registrar Sig | neture | Dere | iace 14 | ne 10, | con the | 7 4 -12 | ./> |
| | Registr | | AUG 18 '97 > Juli | a Davidson | - Pandall | | | | | |

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death **Physician** Month 18, Paul August 1997 Baxter McGinnis 12:00p.m /Medical 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 205 Truslow Road (At Home) Queen Anne's Chestertown 6. Sex 1 ☑ M 2 ☐ F If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) if Undar 1 Yaar 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthpiaca (Stata or Foraign Country) **Funeral** Days 213-05-7245 79 October 2, 1917 Director Maryland Uauai Rasidance of Decedant death with the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examiner must be notified at 1 Tas 2000 Director Maryland Queen Anne's Chestertown 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 205 Truslow Road 21620 U.S.A. Funeral 13. Was Dacedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedant Evar In U,S. Armed Forcas? 14. Race - Amarican Indian, Biack, Whita, etc. Pages 1 and 2 should be filed within 72 hours after of the filed within 72 hours after tent of Health and Mental Hyglene. 1 ☐ Yas 2 ☑ Mo If Yas, Giva Yaar or Datas: 1 Nevar Married 2X Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Fire Equipment Elemantary/Secondary (0-12) Collega (1-4or 5+) Fire Equipment Salesman Sales and Service 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be William R. McGinnis, Sr. Reba Baxter 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 21620 19a. Informant's Name/Ralationship (Type, Print) Department of Health ar Important: If Item 27 Is any Injury or other trau Mary Isabelle McGinnis/Wife 205 Truslow Road, Chestertown, Maryland 20b. Place of Disposition (Nama of cematary, crematory or other place) Data 20c. Location - Cify or Town, Stata 1 █ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Maryland 4 ☐ Donation 5 ☐ Othar (Spacify) Wesley Cemetery/August 21, 1997 Rock Hall
22. Nama and Addrass of Facility Fellows, Helfenbein &
Newnam Funeral Home, P.A.
130 Speer Rd., Chestertown, MD 216 Rock Hall, 21. Signature of Funeral Service Licenses 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarvai Between Onset and Death **Physician** /Medical Immediata Causa (Final ATTC LUNG CARCINOMA disaasa or condition rasulting in daath) Examiner Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequantially list conditions, if any, leading to Immadiate causa. Enter Underlying Cause (Disaasa or Injury that initiated evanta resulting in death) Last Dua to (or as a consequence of) P.O. Box 68760. Physician/Medical Dua to (or as a consequenca of): 88 attending p Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, by page 2 should I 24b. Wara autopsy findinga available prior to completion of cause of daath? Completed 24a. Was an autopsy pariormed? 1 Yas 25 No 1 Yas 2 No certificate Division of Vitai To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p Be 25. Was casa rafarred to medical 26. Placa of Death (Check only ona) axaminar? 1 ☐ Yas 2 No Other: 4 Nursing Homa Rasidanca 6 Other (Specify) Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred Matural 5 Pending invastigation 1 Yas 2 No 2 Accidant 6 Could not be determined 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Certifier Medical 29b. Signatura and titla of certiflar 29c. Licansa number 29d. Data signed (Month, Day, Year) D35048 August 18, 1997 18 30. Nama and addrass of person who complated causa of death (Illim 23a) (Type, Print) Dr. Eric F. Cigarek, 2540 Centreville Rd., Centreville, MD 32. Registrar & Bignatur Davidson-Randelle 31. Data filed (Month, Day (Gar) 2 '9 State

DHMH 16 Rev 6/95

Registrar

State of Maryland / Department of Health and Mental Hygiene 97 27076

| | | | | | Cert | ificate of | Death | 7 | Re | g. No. | - | 1010 |
|---|----------------|--|---|-----------------|-------------------|---|---------------------------|------------------------------|---|-----------------|---------------------------------|----------------------------------|
| Physic | ian | 1. Decedent's Name (First, Middle, La | | | | | | | 2. Date of Death Month | Day | Vear | 3. Time of Death |
| /Med | | Robert | Ignatius | | | Nor | ris | A | ugust 3 | , 1997 | , , , , , | 10:08 P |
| Exami | iner | 4a. Fecility Name (If not institution, give | | | | | | | ation of Death | 4c. County | of Death | |
| | | 44290 St. Andrew | | | | | | liforn | | | Mary's | |
| Funeral | | 5. Social Security Number 6. S | ADM ODE | (In yrs. last I | Yrs. | If Under 1 Year Months Deys | Hours Hours | Min. | 8. Date of Birth (Month, Day, Oct 22, | Year) | 9. Birthplace Country) | e (State or Foreign |
| Director | | 219-36-9492 Usual Residence of Decedent | | 37 | | | 1 | | Ct 22, | 1939 | Mary | Land |
| yland m | | 10e. State 10b. County | | 10c. City, To | wn or Loca | ation | | | | | 10d. | Inside City Limits |
| Mar | tor | Maryland St. Mar | ry's | Ca | lifor | mia | | | | | | 1 ☐ Yes 2√2 No |
| th the 28 | Director | 10e. Street and Number | | | | 10f. Zip Code | | | 10 | g. Citizen of \ | What Country | 7 |
| 23a | | 44290 St. Andrew | vs Church R | oad | | 2061 | 9 | | | U.S. | A. | |
| tems Trans | Funeral | 11. Marital Status | 12. Was Decedent E Armed Forces? | ver in U,S. | 13. Wa | as Decedent of I | Hispanic Or an, Mexice | rigin? (Spec en, Puerto R | ify Yes or No- ican, etc.) | | e - Americen ck, White, etc. | |
| s afte | by F | 1 Never Merried 2 Married 3 Widowed 4 Divorced | 1 Yes 2 No | 0 | | JYes 2₩ No | | | | | w White | |
| 72 hours after death with the Maryland naturel, or flerne 23e or 28e-f show orcel Examinet must be routled at | 8 | 15. Decedent's Ed | Year or Dates: | 16 | a Decedo | nt's Heural Occur | nation | | | Ch Vind of P | uningga Andria | |
| in 72 | Completed | (Specify only highest gra | ade completed) | | (Give ki | nt's Usuel Occup nd of work done NOT use retire | during mos | st of working | ' | OD. KING OF B | usiness/Indus | ry |
| filed within Hygiene. ther than | E | 8th Grade | College (1-4or 5+ | -) | Mea | at Cutte | er | | | Groce | ry Sto | re |
| be filed htal Hygi d other avent, I | BeC | 17. Father's Name (First, Middle, Last, | | | | | T | er's Neme (| First, Middle, M | eiden Suman | ne) | |
| Menta Menta arked | To | Calvert | Ignatius | | No | orris | Ma | ary | Eli | zabeth | | Gatton |
| 2 should end Men is marke | 1 | 19e. Informant's Name/Relationship (| Type, Print) | 19 | b. Mailing | Address (Street | and Numb | per or Rural | Route Number, | City or Town, | State, Zip Co | de) |
| 27 th | | Myrtle Ann Norris | /Spouse | 4 | 4290 | St. And | rews | Churc | h Rd., | Califo | rnia, | MD 20619 |
| Peges 1 tent of Hi nt: If Nen | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ | Removel from State | 20b. Place | of Disposit | tion (Name of tory or other pla | | | | | City or Town, | |
| permit. Peges 1 e Department of Ha: Important: If Item any Injury or othe once. | | 4 □ Donation 5 □ Other (Specif | | Charl | es Me | morial | Garde | ens 8/ | 7/97 I | eonard | dtown, | MD |
| permit. F Departme Importan any Injur | | 21. Signature of Funeral Service Licer | nsee | 1 4 | 22. I | Name and Address: tingley | ess of Fecili | lity | Euporal | Homo | Dλ | |
| 70 F 8 0 | | Michael | Darole | ner | | | | | | | | 650 |
| | | 23a. Pert1. Enter the disease, or comshock, or heart failure. List only | plicetions that caused to one cause on each line | he death. Do | not enter | the mode of dyi | ng, such es | s cardiac or | respiratory arre | st, | Ap | proximete erval Between |
| Physician | | A CONTRACTOR OF THE CONTRACTOR | | | ^ | | | | | | Or | nset and Death |
| /Medical Examiner | | Immediate Cause (Final disease or condition resulting in death) | a by | ng (| an | CCC | | | | | | Vear |
| | <u></u> | | D | ue to or es | conseque | ence of): | | | | | | |
| I Insit | Examiner | | b | - | | | | | | | - | |
| cermicete be asscuted iding physician and ise as the burial-transit | Exa | Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying | D | ue to (or as a | conseque | ence of): | | | | | | |
| ysicia e bur | cai | Cause (Disease or Injury that initiated events | c | ue to (or as a | CORSEGUE | ince of): | | | | | | |
| nding phy | /Medical | resulting In death) Lest | | 00 10 (01 23 2 | oonseque | 1100 017. | | | | | | |
| | | | d | | | | | _ | | | | |
| a atten | sick | Part il. Other significant conditions o | ontributing to death but | not resulting | in the und | erlying cause gi | ven in Part i | 1. | 23b. Did tob | acco uae co | ntributa to the | a causa of death? |
| igned by the a | Physician | | | | | | | | 1 Ye | 8 2 No | 3 Probab | ly 4 Unknown |
| be de | by | | | | | | | | | | | |
| iaw requiras thet the as been signed by th 2 should be detache | Completed | | | | | | | | 24a. Was an perform | autopsy ed? | availai | autopsy findings ble prior to |
| las b | nple | | | | | | | | | | of dea | etion of cause th? |
| page 2 | Con | | | | | | | | 1 🗆 Yes | 2 No | 1 🗆 Ye | es 2 No |
| cartificate rector, pa | Be | 25. Wes case referred to medicei examiner? | Manital | | | | | e of Death (| Check only one |) | | |
| this o | -T | 1 Yes 2 No | Hospital: | | _ | 3LI DOA | | | e 5 Residen | | | |
| The une | Certification: | 27. Manner of Deeth 1 SNatural 5 □ Pending | 28e. Date of Injury (Month, Day | Year) 28b. | Time of Injury | 28c. Inju Wo | | | 3d. Describe hov | v Injury occur | red | |
| deeth. ctor: A y the fu | Icat | 2 Accident Investigation 3 Sulcide 6 Could not be | | A bome | | | Yes 2 | | d Location (Ctr. | not and Alumb | or or O. mi D | nute Abumbaa |
| after deeth Director: / d in by the f | ertif | 4 ☐ Homicide determined | 28e. Place of Injury building, etc. | (Specify) | arm, stree | t, ractory, omce | | 20 | If. Location (Stre City or Town, | | er or murai mo | oute ryumber, |
| within 24 hours after of To the Funeral Direct completely filled in by | S S | 29a. Certifier 11th Certifying Ph | yelcian: To the best of | my knowlede | e death o | courred at the ti | me dete en | nd place, an | d due to the sea | sca/a) and med | annar an atata | d |
| Tospital 24 hours a Funeral D letely filled | edical | | ninar: On the besis of e | xamination e | nd/or Inves | stigation, in my | pinlon, des | eth occurred | at the time, dat | te and place, | and due to the | cause(a) |
| within 2 To the | Me | 29b. Signatury and title of certifier / | | | | 29c. Licens | se number | | 29 | d. Date algne | d (Month, Day | , Year) |
| > F U | | 1 / Jan 11 11 | . // | | | D3 | 991 | 29 | | 910 | 192 | |
| | | 30. Name end eddress of person who | completed ceuse of dea | ath (Item 23e | (Type. Pr | | 1// | -1 | | 0/3 | 11/ | |
| | | William Kelly, | 7 | , | . , ye=>1.1 | • | Leona | ardtow | n, Mary | land | 20650 | |
| Sta | ate | 31. Date filed (Month, Day, Year) | 32 Benistrer | s Signature | | | 200110 | a cow | ٧. ١٠٠٠ | | -0030 | |
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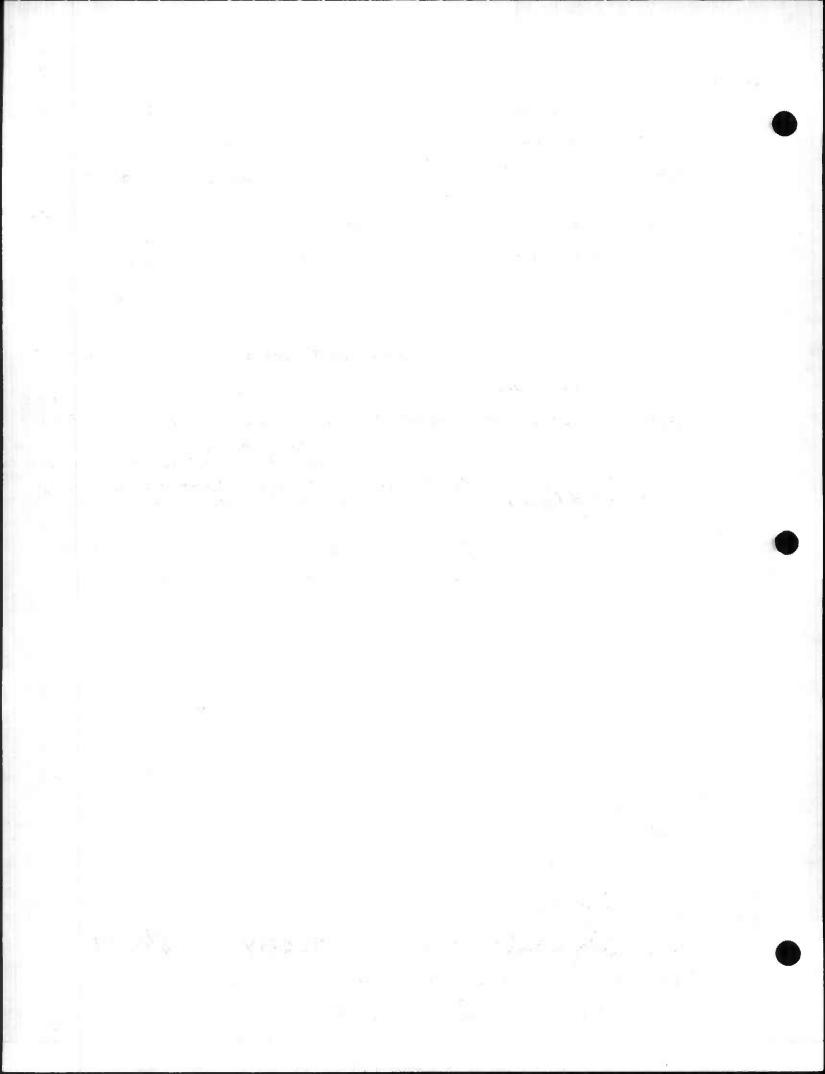
Registrar DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Deta of Deeth 3. Tima of Deeth **Physician** Dey Yaeı Patricia Patterson Norris 18, 1997 August 4:45 a.m. /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 25840 Collins Avenue (At Home) Chestertown Kent If Under 1 Yaar Months Days If Under 24 Hrs. Hours Min. 5. Sociel Sacurity Number 7. Age (In yrs. lest birthday) 8. Data of Birth (Month, Dey, Year) **Funeral** Birthpieca (Stete or Foraign Country) 1 M 200 Hours 206-18-4185 **Director** April 7, 1925 Pennsylvania Usual Residence of Decedent with the Maryland 10e State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2XX Directo Maryland Kent Chestertown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 25840 Collins Avenue Funeral deeth 21620 U.S.A.

14. Reca - Amarican Indian,
Black, White, etc. 12. Wes Decedent Evar in U,S. Armed Forces? Wes Dacedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, atc.) permit. Pages 1 end 2 should be filed within 72 hours after of Department of Health and Mental Hygiena. Important: If them 27 is marked other than "natural", or item any injury or other traumate excep-1 ☐ Nevar Marriad 2 ☐ Married 1 Yes 2 No If Yas, Give Yaer or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorcad Specify: White 16e. Decedent's Usual Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Spacify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 Laboratory Technician Medical/Hospital 17. Father's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Meiden Sumeme) Charles F. Patterson Elisabeth Lord 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21620 William H. Norris, Jr./Husband 25840 Collins Avenue, Chestertown, Maryland 20b. Plece of Disposition (Name of cametery, cremetory or other pleca August 19, 1997 20c. Location - City or Town, Steta 20e. Method of Disposition 1 ☐ Burlal 2 ☑ Cremation 3 ☐ Removel from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Chesapeake Cremation Center, LLC/Stevensville, Maryland 21. Signeture of Funeral Service Licenses Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620 2 23a. Pert1. Enter the disease, or complicate shock, or heert tailure. List only one that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, as on each line. Approximete Intervel Between Onset and Deeth Physician /Medical Immediate Cause (Finel LUNG disease or condition resulting in deeth) Examiner Examiner years the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of): pue P.O. Box 68760, ding physician certificata be Physician/Medical Dua to (or es e consaguance ot) 88 atten 23b. Did tobasco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by 1 Nos 2 No 3 Probably 4 Unknown Division of Vital Records. by 90 Completed 24e. Wes en eutopsy performed? 24b. Were eutopsy findings aveilable prior to completion of causa of deeth? certificate has 1 Yes 1 Yes 2 100 25. Wes case reterred to medical exeminer? Be 26. Plece of Deeth (Check only one) 2 3 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 27. Manner of Deeth To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral 28e. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 3 Sulcide 6 Could not be determined 28e. Plece of Injury - At home, term, street, tectory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check ont ner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) menner stated. 295. Signature and title of portifier 29c. License number 29d. Data signed (Month, Dey, Year) M hora 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Patrick J. Shanahan, 120 Speer Road, Suite II, Chestertown, Maryland 31. Date tiled (Month, Day, Year) State Gulia Davidson-Randalle Registrar

DHMH 16 Rev 6/95



WRC 97-4479-037 JONNIE A. OWEN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Months

10f. Zip Code

State of Maryland / Department of Health and Mental Hygiene Q 7

Deys

Certificate of Death

2. Deta of Death

Physician /Medicai **Examiner**

Johnnie Anthony 4a. Facility Nama (If not institution, giva street and number)

St. Mary's

10b. County

1 **■** M 2 🗆 F

Month AUGUST

3. Time of Deeth Yaar

Birthpieca (Steta or Foraign Country)

10d. Inside City Limits

1 ☐ Yes 2 ■ No

4b. City. Town, or Location of Deeth

LEXINGTON PARK

|f Undar 1 Yaar | If Under 24 Hrs. | 8. Date of Birth | Months | Deys | Hours | Min. | (Month, Dey, Year)

10, 1997 3:15 AM. 4c. County of Death

St. Mary's

10g. Citizen of Whet Country?

February 6, 1963 Virginia

Funeral Director

28a-f show items 23a 72 hours after "natural", or Director Funeral by Completed

7 is marked other than "natural", or items 23s or 28a-f shov traumstic event, the Madical Examinar must be notified at permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If fem 27 is marked other than "s any finlury or other traumatic event, its thin.

Baltimore, Maryland 21215-0020

Physician /Medicai Examiner

physician and the burial-transit The law requires that the death certificate be executed Box 68760. USB ō signed by the a d be datached f P.0. Records, paga 2 Division of Vital or Attending Physician: this funaral Aftar s after dec. filled in n 24 hours a Hospital

Examiner Physician/Medical þ Completed Be Certification: To

1. Decedent's Name (First, Middle, Last) POINT LOOKOUT DR. 5. Social Security Number 229-54-5164 Usuel Residence of Decedent 10a. Stete Maryland 10e. Street end Number 11. Meritel Status 17. Fether's Neme (First, Middle, Last) Charlie Junior Owen 2 19e. Informent's Neme/Relationship (Type, Print) Donna M. Owen, Wife 20e. Mathod of Disposition

1 ■ Burial 2 □ Cremation 3 ■ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Michael K. Brankenship, MO0857 Immediete Ceuse (Finei disaese or condition resulting in deeth) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Wes case referred to medical 1X Yes 2 No 27. Menner of Deeth 1 Neturei 5 Pending Accident 3 Suicide

4 Homicide

(Check only one)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) and mennar es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piaca, end due to tha cause(s) end manner steted.

28e. Dete of Injury (Month, Dev Year)

1097

29c. Licanse number

28b. Time of

28e. Place of Injury - At home, farm, street, fectory, office building, atc. (Specify)

02051M

O.C.M.E.

28c. Injury et Work?

1 Yas 2 No

29d. Dete signed (Month, Day, Year)

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

MARIDAMO A KONSU W 111 Penn Street, Baltimore, Maryland 21201

31. Dete filed (Month, Dey, Year) AUG 14

investigation

6 Could not be determined

32. Registrer's Signeture

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

RODOWAY

State Registrar 7. Age (In yrs. lest birthday)

34

Yrs

10c. City, Town or Location

Great Mills

Ernestine Bailey

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)

22048 Baja Lane, Great Mills, Maryland 20634 20b. Plece of Disposition (Neme of cematery, cremetory or other plece) 20c. Location - City or Town, Stata

> 8/15/97 Cluster Springs, Virginia 22 Name and Address of Facility
> Brinsfield Funeral Home, P.A.

22955 Hollywood Road, Leonardtown, Maryland 20650-0279 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line.

Approximete Interval Betw

HULTIPLE INJUNIES Due to (or es e consequence of)

Owens Grove Cemetery

Due to (or es e consequence of):

Due to (or es e consequance of):

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24e. Wes en eutopsy performed? 24b. Were autopsy findings aveilable prior to completion of cause of deeth?

1 Nes 2 No 1 Yes 2 No

26. Plece of Deeth (Check only one) AT Other: 4 Nursing Home 5 Residence 8 Mother (Specify)

SCENE 28d. Describe how Injury occurred PEDESMIAN SMULL BY CAN

28f. Location (Straet end Number or Rural Routa Number, City or Town, Stete) POINT LOOKOUT RD ST HARY'S W

AUGUST 10, 1997

DHMH 16 Rev 6/95

To the Hosp within 24 ho To the Fune complately fi

Please Type or Print in Black Indeiibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q 7 2 7 0 7 9

| | | | | | State of IV | iaiyiaiiu / | Certificate | | т ментат пу | Reg. No. | 1 4 | 1019 |
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| П | Physic | an | Decedent's Neme (First | Middle, L | ast) | | | | 2. Dete of De Month | eth Dey | Year | 3. Time the |
| J | /Medi | | | D. | Osborne | | | - | August | 25 1 | 997 | 2:05p.m. |
| и | Exami | ner | 4e. Fecility Neme (If not in | | | | | 4b. City, Town, o | or Location of Deet | 4c. County | of Deeth | |
| Н | | | 10065 Mar 5. Social Sacurity Number | | | Road | nirthday) If Under 1 Y | White P | | Cha | rles | |
| | Funeral Director | | 577-44-1348 Usuel Residence of Deced | | \$9X XXM 2□ F 7. A | 64 | | ays Hours Mi | in. (Month, De | Vear) 0, 1933 | HUD | SON N.C. |
| | show | | and the second second | County | 50 | | wn or Location | | | | 1 | IOd. Insida City Limits |
| | e Me | ctor | MD. | CHARL | .ES | MHT | TE PLAINS | | | | | 1 □ Yas XX No |
| | with th | Director | 100. Street and Number | LIAL L | CODNED DD | | 10f. Zip Co | | | 10g. Citizan of | What Cour | ntry? |
| | eath | erai | 10065 MARS | HALL | 12. Was Deceden | | 2069 | | (Capally Van or No | USA | o - Americ | can Indian, |
| 21215-0020 | 72 hours after death with the Meryland natural; or items 23s or 28s-f show dical Examinal must be notified at | by Funeral | 1 Nevar Marriad 2(| | Armed Forces 1 XYas 2 If Yes, Give Yeer or Detes: | [?] No1953- | If Yes, specify | of Hispanic Origin? Cuban, Maxican, Put (No Specify: | arto Rican, etc.) | Ble | ck, Whita, | etc. |
| 2-0 | 72 hours netural', | | 15. De | cedent's E | Education | | a. Decedent's Usuai O | ccupation | and the a | 16b. Kind of B | usinass/in | dustry |
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| 12 | ified withing the hand the han | | 8 17. Fether's Neme (First, A | Aintella, Las | 0 | | BOOKBINDE | | | U.S. G | | MENT |
| and | A S P S | o Be | BRADLEY HIC | | | | | | leme (First, Middle | | | |
| Maryland | SPEE | То | 19e. Informent's Neme/Re | | | 19 | b. Meiling Address (St. | | | | | Code) |
| | 5 m 0 F | | KELLY M. FI | NAMOR | RE /DAUGH | TER | 2238 BRIDE | DLE PATH D | DRIVE | | | H-1 - |
| altimore, | 8 6 T | | 20a. Method of Disposition 1 X Buriel 2 Crem 4 Dogeljon 5 O | ation 3 l | □Removal from State | cemei | of Disposition (Neme of ery, cremetory or other VETERANS (| r place) | Dete 09-02-97 | 20c. Location | City or To | |
| alt | pemit. Peg Department Important: I any Injury o | | 21. Signature of Fuderal S | engice Uci | 9000 0 00 | - | The state of the s | ddress of Facility | | | | |
| œ | 20199 | MA | MARK G. | BROHA | WN M0005 | 3 | HUNTT FU | JNERAL HOM | ME INC. | n 156 | | |
| | | | 23e. Pert1. Enter the dise shock, or heert fellure | sa, or cor | nplicetions thet cause y one ceuse on each | d the deeth. Do | not anter the mode of | dying, such as card | iac or respiretory e | flest, | | Approximete Interval Between |
| | Physician /Medical | | Immediate Cause (Final | | | | | | | | i | Onset and Death |
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| | | Jer | | | | Due to (or as | consequence of): | | | | 1 | |
| | ficate be axecuted physician and is the burial-transit | Examiner | Sequentielly list conditions | | b | Due to (or es | consequence of): | | | | + | |
| 30, | olan a | | Sequentially list conditions if any, leeding to immediat cause. Enter Underlying Cause (Disease or Injury) | | | | | | | | i | |
| 68760, | physic the b | edical | that initieted events resulting in deeth) Last | 1 | C | Due to (or as a | consequence of): | | | | | |
| | 35 13 6 | | | L | d | | | | | | | |
| Box. | death cert e attending ed for use | Physician/M | Part II. Other significant co | nditions | contribution to don't | but not requities | In the underlying source | a atrea la Dest I | ook Did | | | Abo 2010 of d -100 |
| P.0 | that the de ed by the a detached t | hys | Partii. Other argimicant co | MUMOUS | contributing to death t | out not rasulting | in the underlying cause | e given in Part I. | | Yes 2 No | 3 ☐ Prof | the cause of death? |
| | S 5 8 | by F | | | | | | | - | | | |
| of Vital Records, | v requires that the been signed by th should be detache | | | | | | | | 24a. Waa perfo | en autopsy | av | ere autopsy findings allable prior to |
| eco | 2 S S | Completed | | | | | | | | | of | mplation of cause death? |
| al R | E SE | Co | | | | | | | 10 | Yes 2 No | 10 | Yes 2 No |
| Vita | Physician: The this certificate ral director, page | Be | 25. Wes case referred to n exeminer? | nedical | Hospitel: | | | Other: | eeth (Check only o | | | |
| | Physical di | 1: To | 1 Yes 2 Ho | | 1 Inpati | | | 4 LI Nursing | Home 5-Resi | dence 6 Oth | 1-7 | N) |
| ion | Attending I ir death. ector: After by the funer | ation | | ending nvestigetion | (Month, De | y Year) | | Injury at Work? 1 Yes 2 No | | ,, | | |
| Division | or Attendi aftar death. Director: A I in by the fo | ertification: | 3 ☐ Suicide 6 ☐ 0 | Could not betermined | 286. Piece of in | jury - At home, | erm, street, fectory, off | fice | | | per or Rura | I Route Number, |
| Ö | rs after or all Dir | Cerl | 4 - Homicoe | | building, e | tc. (Specify) | | | City or To | WII, SIEIR/ | | |
| | To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the fune | edicai | 29e. Certifler 11 Ce (Check only one) 2 11 Me | rtifying Pi dical Exa | hysician: To the best miner: On the basis of and manner st | of examinetion e | e, deeth occurred at th nd/or invastigetion, in n | ne time, dete and ple my opinion, deeth oc | ce, end due to the curred at the time, | cause(a) end ma dete and piace, | enner as si and due to | leted. the cause(s) |
| | To the within 2 To the comple | Σ | 29b. Signeture and title of | ertifier | | A | 29c. Lic | cense number | | 29d. Dete signe | d (Month, | Dey, Year) |
| | | | Horris | l- | 1(. | 100 | D2 | 28352 | | Augus | t 26 | , 1997 |
| | | | 30. Neme end address of p | | | | | | | | | |
| | | | Krishan Ma | | | | . Box 272 | 29, La P | lata, M | 206 | 46 | |
| | Sta Registr | | | | 97 Julia | rer's Signeture | 0 | | | | | |
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| e Igw | has t | Dept | 23 |
| 2 | DR: After this certificate has been signed by the attending physic | State | Item |
| SICIA | certif | the | 0 |
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| TEN | HOL | after | 28 1 |
| OR A | DIREC | SUUC | шеш |
| TAL | RAL | he filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation | I H I |
| HOSP | FUNE | within | TANT |
| THE | THE | filed y | PORT |
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| | FOR 1 . STATE | STATE OF MAR | | | | | WENTAL | | E | 97 | 27080 |
|---------------------------------------|---|--|--|--|---|---|--|--|------------|---------------------------------------|---|
| | REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) | | CER | TIFICA | IE OF | DEATH | 2 DATE | REG. NO. | | | TIME OF DEATH |
| | Nellie NMN | PARSHAL | L | | | | MONTH | | | YEAR | 5:55 p. M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 8. A | NGE (In yrs. lest birth | | NOER I YEAR | IF UNDER 24 HRS. | 7. DATE C | OF BIRTH | 1 | | ACE (State or Foreign |
| | 292-20-1276 | 1 M 2 X F | 96 v | /RS. MONTH | HS DAYS | HOURS MIN. | Feb. | 22, | 1901 | Wes | t Virginia |
| OR | On FACILITY NAME (If not Institution, give str Clearview Nursing | · · · · · · · · · · · · · · · · · · · | | 9b. C | | R LOCATION OF DE | | | | shing | |
| ECT | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | 10 | c. CITY, TOV | VN OR LOCAT | ION | | | | | Od. INSIDE CITY |
| L DIRECTOR | Maryland Wash: | ington | |] | Hagers | town zip code | | | | , | LIMITS? YES 2 NO AT COUNTRY? |
| FUNERAL | 18354 Woodside D | | | | | 2 | 21740 | | | | USA |
| В | 11. MARITAL STATUS 1 Never Married 2 Married 3 M Widowed 4 Divorced | 12. WAS DECEDENT EV FORCES? 1 1 1 IF YES, GIVE WAR C | VES 2 K NO | | If yes, spi | ENDENT OF HISPAN Helfy Cuban, Maxica 2 [X] NO Specify | n, Puarto A | | or No— | Black, Specify: | - American Indian, White, atc. hite |
| COMPLETED | 15. DECEDENT'S EDUC. (Specify only highest grade of | completed) | (Give kii | ENT'S USUA ind of work do NOT use retire | L OCCUPATIO | N st of working | 16b. | KIND OF BUS | SINESS/IND | USTRY | |
| PLE | Elementary/Secondary (0-12) | College (1-4 or 5+) | | .P.N. | , | | - 1 | hospi | tal | | |
| OM | 17, FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTHER'S NA | ME (First, M | | | | |
| BE C | Charles Mason | | | | | Marri | letta | Hudso | n | | |
| TO B | 194. INFORMANT'S NAME (Type/Print) Francine DeNobrega | a | | | | nd Number or Rural I iamsport | | | | | |
| | 20a. METHOD OF DISPOSITION 1 | wat from State | 20b. PLACE AND Cometery, cremator Hagers | ory or other pla | acel | | DATE 3-24- | | CATION — | - | , State , Maryland |
| | 21. SIGNATURE OF FUNETIAL SERVICE LICE | ENSEE | nagers | 5 COWII | 22. NAME AN | ID ADDRESS OF FA | CILITY M | TNNTCL | iager: | EDAT | UOME |
| | Scotto | Menn | eel | | | | | | | | Md. 21740 |
| | 23. PART I. Enter the diseasea, or cannot have abook, or heart feiture. L. IMMEDIATE CAUSE (Final disease or condition resulting in deeth) | omplications that callet only one ceuse of a Acute Myor DUE TO (OR | on eech line, | | | | h aa card | lac or reap | ratory arr | eat, | Approximata Interval Between Onset and Death 15 min. |
| RTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | Arteriosc. DUE TO (OR | AS A CONSEQUEN | NCE OF): | t Dise | ase | | | | | many years |
| | CAUSE (Disease or Injury that initiated eventa resulting in death) LAST | DUE TO (OR | AS A CONSEQUE! | NUE OF): | | | | | | | |
| CE | that initiated eventa | 1. | | | e underlyln | g ceuse given in | Part I. | 24s. WAS AN | | | VERE AUTOPSY FINDINGS |
| CE | PART II. Other algorificent conditions Dementia of Alzhe | s contributing to dee | oth but not recul | | e underlyln | g ceuse given in | Part I. | 24s. WAS AN PERFOR | MED? | 1 | WAILABLE PRIOR TO COMPLETION OF CAUSE |
| CE | that initiated eventa resulting in death) LAST PART II. Other algnificent conditions | s contributing to dee | oth but not recul | | e underlyln | g couse given in | Part I. | PERFOR | MED? | 0 | WAILABLE PRIOR TO |
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| MEDICAL CE | PART II. Other algnificent conditions Dementia of Alzhe Recent bilateral DID TOBACCO USE CONTR | e contributing to dee eimers type pneumonia RIBUTE TO CAUS | E OF DEATH | YES T | NO [| | | PERFOR | MED? | 0 | MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
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| PHYSICIAN: MEDICAL CE | PART II. Other algnificent conditions Dementia of Alzhe Recent bilateral DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending | e contributing to dee eimers type pneumonia RIBUTE TO CAUS | E OF DEATH 26. PLACE OF | YES TO THE TOTAL OF THE TOTAL O | NO Lineck only one) MER: Nursing Horrival 28c, INJ WC | UNCERTAII | N D | PERFOR | MED? | 1 | MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| BY PHYSICIAN: MEDICAL CE | PART II. Other algorificent conditions Dementia of Alzhe Recent bilateral DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH | contributing to dee cimers type pneumonia RIBUTE TO CAUS HOSPITAL: 1 Inpetient 2 ER 28e. DATE OF INJI (Month, Day, M | E OF DEATH 26. PLACE Of //Outpetient 3 DURY 28 JURY At home, | YES DEATH COME A | NO Check only one) HER: Nursing Hom 28c, INJ WC 1 | UNCERTAII e 5 Residence URY AT RK? rES 2 NO | 8 Other | PERFOI 1 VES 2 | NJURY OCC | CURED | MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
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| BE COMPLETED BY PHYSICIAN: MEDICAL CE | PART II. Other algnificent conditions Dementia of Alzhe Recent bilateral DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicida 6 Could not be detarmined 4 Homicide 1 CERTIFYING PHYSIC (Check only) | s contributing to dee eimers type pneumonia RIBUTE TO CAUS HOSPITAL: 1 Inpatient 2 ER 28a. DATE OF INJ 6 (Month, Day, W 28e. PLACE OF IN, building, stc. CIAN: To the best of my IR | E OF DEATH 26. PLACE OF //Outpatient 3 □ E URY 28 JURY — At home, (Specify) | YES L F DEATH (Ch DOA 4 (A) Sb. TIME OF INJURY farm, street, | NO Lineck only one) HER: Nursing Hom 28c, INJ. WC 1 1 | UNCERTAII • 5 Rasidence UNY AT RK? YES 2 NO a and place, and dua eath occured at the 29c. LICENSE NUI | 8 Others 28d. DES 28f. LOCICity of to the cause time, data | PERFOR | NJURY OCC | CURED Or Rural Ro. ed. e cause(e): | WALLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? VES 2 NO VIEW Number, ute Number, and manner as stated. |
| COMPLETED BY PHYSICIAN: MEDICAL CE | PART II. Other algnificent conditions Dementia of Alzhe Recent bilateral DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicida 8 Could not be detarmined 4 Homicide 8 Could not be detarmined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PENSON WHO | B contributing to dee Simers type Preumonia RIBUTE TO CAUS HOSPITAL: 1 Inpatian: 2 ER 28s. DATE OF INJ (Month, Day, W 28s. PLACE OF IN, building, atc. | E OF DEATH 26. PLACE OF //Outpetient 3 DE UNITY At home, (Specify) knowledge, death of nation and/or investigations. | YES L F DEATH (Ch DOA 4 (A) Sb. TIME OF INJURY farm, street, | NO Lineck only one) HER: Nursing Hom 28c, INJ, WC 1 Line the time, dete | UNCERTAIL 5 Residence UNY AT RK? /ES 2 NO and place, and dus eath occured at the 29c. LICENSE NUI | 8 Other 28d, DES 28f, LOC, Chy o | PERFORM 1 VES 2 (Specify) CRIBE HOW (ATION (Street or Town, State) se(s) and mai | NJURY OCC | CURED Or Rural Ro | MARLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH! VES 2 NO VIES 2 NO Ute Number, and manner as stated. |
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State of Maryland / Department of Health and Mental Hygiene 97 2708

| | | 1. Decedent's Neme (First, Middle, L. | 41 | | | | | | eg. No. | | 1 |
|---|--|--|--|--|--|---|---|--|--|--|--|
| Physic | cian | Jeffery Allen P | | | | | | 2. Data of Dea Month | Dev | Year | 3. Time of Death |
| /Med | | 4e. Facility Neme (If not Institution, gr | | | | | 4b. City, Town, or | August | 21, 19 | | 11,100 |
| Exam | iner | 9 East Lee Stre | VIII-LACOR IN CIT. | | | | | rstown | | shing | gton |
| Funera Directo | | 215-64-1171 | Sex 7. Age 120 M 2 □ F 4 | e (In yrs. last | Yrs. If Unc Month | der 1 Yaar Is Days | If Under 24 Hrs Hours Min. | 8. Dale of Birth (Month, Day March | Year) 5,1956 | 9. Birthp Coun Mary | lece (Stete or Fore try) y Land |
| M TI | | Usual Residence of Decedent 10a. Stete 10b. County | | 10c. City, T | own or Location | | | | | 1 | 0d. Insida City Limi |
| 28a-f ehow | cto | Maryland Washin | gton | | Hagerst | own | | | | | 1 Yes 2 □ N |
| 23a or 28 | rai Director | 10e. Street and Number 9 East Lee Stree | t | | 10f. 2 | Zip Code 217 | 40 | 1 | 0g. Citizen of V | What Coun USA | itry? |
| mous / z stous area beast wist to maryand than "naturel", or items 23s or 28s-f show the Modical Examiner must be notified at | by Funeral | 11. Marital Stalus 1 🖾 Never Married 2 🗆 Merried 3 🗆 Widowed 4 🗆 Divorced | 12. Wes Decedant I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Yaar or Detes: | | | | lispanic Origin? (S an, Mexican, Puerl Specify: | pecify Yes or No- lo Rican, etc.) | | e - Amaric ck, White, | |
| ene. than "natu | Completed | 15. Decedent's Elementery/Secondery (0-12) | | 1 | | | ation during most of word) | rking | 16b. Kind of Bu | | |
| | | 10 | 0 | | 1abor | er | | 450 - 4414 | roofin | | npany |
| the airt and Mental Hygiene. tem 27 le marked other than other treumatic event, the | To Be | 17. Fether's Name (First, Middle, Las John Louis Perro | | | | | | na (First, Middle, I are Lois | | | |
| and M le mari | - | 19e. Informant's Name/Reletionship | (Type, Print) | 1 | 19b. Meiling Addre | ess (Street | end Number or Ru | ıral Route Numbei | , City or Town, | State, Zip | Code) |
| f Health item 27 other tre | | John L. Perrott, | Jr. | | 12 Cataw | ba Ci | rcle, Ha | gerstown | , Maryl | and 2 | 21742 |
| , J | | 20a. Method of Disposition 128 Burial 2 Cremetion 3 [4 Donetion 5 Other (Special Contents) | | ceme | e of Disposition (A etery, crametory o Hill Ce | r othar pla | , | | 20c. Location - Hagerst | | wn, Stete Maryland |
| Department of Important: If eny injury or once. | No. | 21. Signature of Funeral Service Lice | Min | 11 10 | | | ss of Fecility M | INNICH F | | | 1740 |
| nysician Medical xaminer | 1 | Immediate Cause (Final disease or condition | 50 | X | ./ " | | ` - | | | | Approximate Interval Between Onset and Death |
| g physicia as the bur | her | resulting in deeth) | Me | Surfic (bi as | y consequence of | 4 · | DY | xicity | + | 6 | vee to |
| as the | VMedical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | 0 | Roll Due to (or as | a consequence of | 7. | D 7 | xicity | + | 9 | vee to |
| attending phys for use as the | ledical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c | Due to (or as | a consequence of | 7 n: | | | | 9 | vee to |
| ed by the attending physical detached for use as the | Physician/Medical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events | c | Due to (or as | a consequence of | 7 n: | | 23b. Did to | | tribute to | the cause of deal |
| se been signed by the attending physics should be detached for use as the | by Physician/Medical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c | Due to (or as | a consequence of | 7 n: | | 23b. Did to | es 2□ No | 24b. We | and 4 Union |
| has been signed by the attending phys- ge 2 should be detached for use as the | by Physician/Medical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c | Due to (or as | a consequence of | 7 n: | | 23b. Did to 1 7 Y | es 2□ No | 24b. We ave of c | ### 4 □ Unike |
| ate has been signed by the attending physicage 2 should be detached for use as the | Physician/Medical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c | Due to (or as | a consequence of | 7 n: | en in Part I. | 23b. Did to 1 7 Y | nbacco use cor es 2□ No n autopsy ned? | 24b. We ave of c | and autopsy finding sitable prior to impletion of cause death? |
| certificate has been signed by the attending physicador, page 2 should be detached for use as the | Completed by Physician/Medical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes Yes | d | Due to (or as | a consequence of a consequence of g in the underlying | 7 r): r): g cause giv | en in Part I. 26. Place of Dec | 23b. Did to 1 Y 24a. Was a perfor | nbacco use cor es 2□ No n autopsy ned? | 24b. We ave oor of the second | ably 4 ☐ Union are sutopey finding sitable prior to replation of cause death? Yes 2 ☐ No |
| After this certificate has been signed by the attending physiumanal director, page 2 should be detached for use as the | To Be Completed by Physician/Medical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions 25. Was case referred to medical examiner? | d | Due to (or as | a consequence of | ODOA Othor | en in Part I. 26. Place of Dec | 23b. Did to 1 Y 24a. Was a perfor | n autopsy med? | 24b. We ave out of a | re sutopsy finding silable prior to replation of cause death? Yes 2 No |
| ifter death. Ptrector: After this certificate has been signed by the attending phys in by the tuneral director, page 2 should be detached for use as the | To Be Completed by Physician/Medical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II, Other significant conditions 25. Was case referred to medical examiner? 1 Yes | d | Due to (or as Due to (or as ut not resultin y year) 281 | a consequence of a consequence of a consequence of g in the underlying in the underlying to the underlying b. Time of linjury | ODA Oth | en in Part I. 26. Place of Del 87. 4 □ Nursing H | 23b. Did to 1 Y 24a. Was a perform | n autopsy med? | 24b. We avisor of the set (Specif) and | ably 4 Unknown autopsy finding silable prior to moletion of cause death? □ Yes 2 № No |
| Whours after death. Paranai Director: After this certificate has been signed by the attending physically filed in by the funeral director, page 2 should be detached for use as the | Certification: To Be Completed by Physician/Medical | Sequentially list conditions, if any, leading to immediate cause. Enter Underfunding Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions 25. Was case referred to medical examiner? 1 | Hospital: 1 Inpetie 28a. Date of Injur (Month, Day 28e. Place of Injur building, etc. | Due to (or as Due to (or as It not resulting It now in the control of my knowled application | a consequence of a cons | DOA Oth 28c. Injur Wor 1 Ory, office | en in Part I. 26. Place of Der 8°: 4□ Nursing H yal k? Yes 2□ No | 23b. Did to 1 Yeard Was a performance of Residue 10 Yeard Check only or Town 28d. Describe house of the control | n autopsy med? ss 2 No n autopsy med? so 6 Othorwinjury occur reet and Numb | 24b. We ave oor of s | ably 4 Unknown series autopey finding allable prior to moletion of cause death? □ Yes 2 □ No □ Route Number, |
| Whours after death. Paranai Director: After this certificate has been signed by the attending physically filed in by the funeral director, page 2 should be detached for use as the | To Be Completed by Physician/Medical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II, Other significant conditions 25. Was case referred to medical examiner? 27. Manner of Death Natural 5 Pending investigation | d | Due to (or as Due to (or as It not resulting It now in the control of my knowled auditination | a consequence of a cons | DOA Oth 28c. Injur Wor 1 Ory, office | 26. Place of Der 65: 4 Nursing N 48 Yes 2 No | 23b. Did to 1 Year Year Year Year Year Year Year Year | n autopsy med? ss 2 No n autopsy med? so 6 Othorwinjury occur reet and Numb | 24b. We ave on of the average of the | ably 4 Unknown autopey finding silable prior to moletion of cause death? 3 Yes 2 □ No 4 Route Number, stand. |
| after death. Director: After this certificate has been signed by the attending phys in by the tuneral director, page 2 should be detached for use as the | edical Certification: To Be Completed by Physician/Medical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II, Other significant conditions 25. Was case referred to medical examiner? 1 Yes Salo 27. Manner of Death Pending investigatic Suicide Could not I determined 2 Accident Could not I determined 29a. Certifier (Check only one) | Hospital: 1 Inpetie 28a. Date of Injur (Month, Day 28e. Place of Injur building, etc. | Due to (or as Due to (or as It not resulting It now in the control of my knowled auditination | a consequence of a cons | Oth Oth DOA OTH, office ond at the financian, in my o | 26. Place of Der 65: 4 Nursing N 48 Yes 2 No | 23b. Did to 1 Year Year Year Year Year Year Year Year | bacco use core 2 No n autopsy med? se 2 Other will ance 6 Other will meet and Numb xuse(s) and ma ate and place, i | 24b. We ave on of the average of the | ably 4 Unknown autopsy finding aliable prior to mpletion of cause death? □ Yes 2 □ No □ Route Number, aliad. the cause(s) |
| 14 hours after death. Patransa Director: After this certificate has been signed by the attending physically filled in by the funeral director, page 2 should be detached for use as the | edical Certification: To Be Completed by Physician/Medical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II, Other significant conditions 25. Was case referred to medical examiner? 1 Yes Salo 27. Manner of Death Pending investigatic Suicide Could not I determined 2 Accident Could not I determined 29a. Certifier (Check only one) | Hospital: 1 Inpetie 28a. Date of Injury (Month, Day 28e. Place of Injury building, etc. 28e. Place of Injury building, etc. | Due to (or as Due to (or as It not resultin It 2 EPV Year) 28I Iny - At home. (Specify) | a consequence of a cons | DOA Other | 26. Place of Der 65: 4 Nursing N 48 Yes 2 No | 23b. Did to 1 1 Y 24a. Was a performant (Check only or lower 28d. Describe to City or Town), and due to the curred at the time, d | n autopsy med? se 2 No n autopsy med? se 2 No no 6 Oth w injury occur reet and Numb 1, State) ause(s) and ma ate and place, i | 24b. We soon of the soon of th | ably 4 Uniter autopsy finding stable prior to mpleton of cause death? Yes 2 No Route Number, stab. the cause(s) |

DHMH 16 Rev 6/95

-1 19 NO 3- 11

State of Maryland / Department of Health and Mental Hygiene Q Item 28d per MEO Film G751 9-17-97 rja Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** JEFFERY DEAN RAMEY AUGUST 1997 4:15 pm /Medical 4e. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner NAVAL AIR STATION PAX RIVER PATUXENT RIVER ST MARYS 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Year | If Under 24 Hra. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days 1 € M 2 □ F Houra Director 576-67-2821 94HONOLULU, MARCH Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location show 10d. Inside City Limits ir than "natural", or items 23a or 28a-f short the Medical Examiner mant be notified at 1 □ Yas 2 □ No Director ST MARYS MD PATUXENT RIVER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1516 E CONRAD HEIGHTS 20670 UNITED STATES death Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 Yes ANO
If Yes, Give 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merifel Status 14. Rece - American Indian, Bleck, White, etc. hours efter Never Married 2 Merried Baltimore, Maryland 21215-0020 1∰ Yes 2□ No Specify: p Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Uauel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 N/A N/A pernit. Peges 1 and 2 should be filed to Department of Health and Mental Hygie Important: If hem 27 is marked other 1 eny Injury or other treumatic event, If 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be KENNETH DEAN RAMEY BARBARA A. DALEY 19a, Informent'e Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KENNETH D. RAMEY FATHER 1516 E Patuxent River, MD 20670 20b. Place of Disposition (Name of cemetery, crematory or other place) 8/4/97 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY ALEXANDRIA, VA 21. Signature of Funeral Service Licenses 22. Name end Address of Facilit Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland ines 23a Part1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onser and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) DROWNING Examiner Due to (or as a consequence of): buriel-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): and P.O. Box 68760. physician Physician/Medical \$ Due to (or as a consequenca of) USB as for use as Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t Records, þ 24b. Were sutopsy findings aveilable prior to completion of cause of death? page 2 should Completed 24a. Was an autopsy performed? Deen The law certificate hes 1√2Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical Be 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) pond Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3€ DOA 10 1☐xYes 2☐ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28c. Injury at Work? Certification: 28b. Time of 5 Pending Investigation 1 Netural s efter death. I Director: Aft of in by the fur 1 Yes **XX**Accident 1615 Subject fell into pond Aug 1 07 1615 "
28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 3 ☐ Sulcide 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 Homicide Pax RiverNAS, MD pond on base 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifies (Check only 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) CA GFE 72823 August 2, 1997 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LCDR MC US 32. Registrar's Signature CRAIG MALLAK,
31. Date filed (Month, Day, Year)
AUG 5 USN NNMC Bethesda, MD

alia Davidson Rardall

DHMH 16 Rev 6/95

State

Registrar

to Silver and the Man

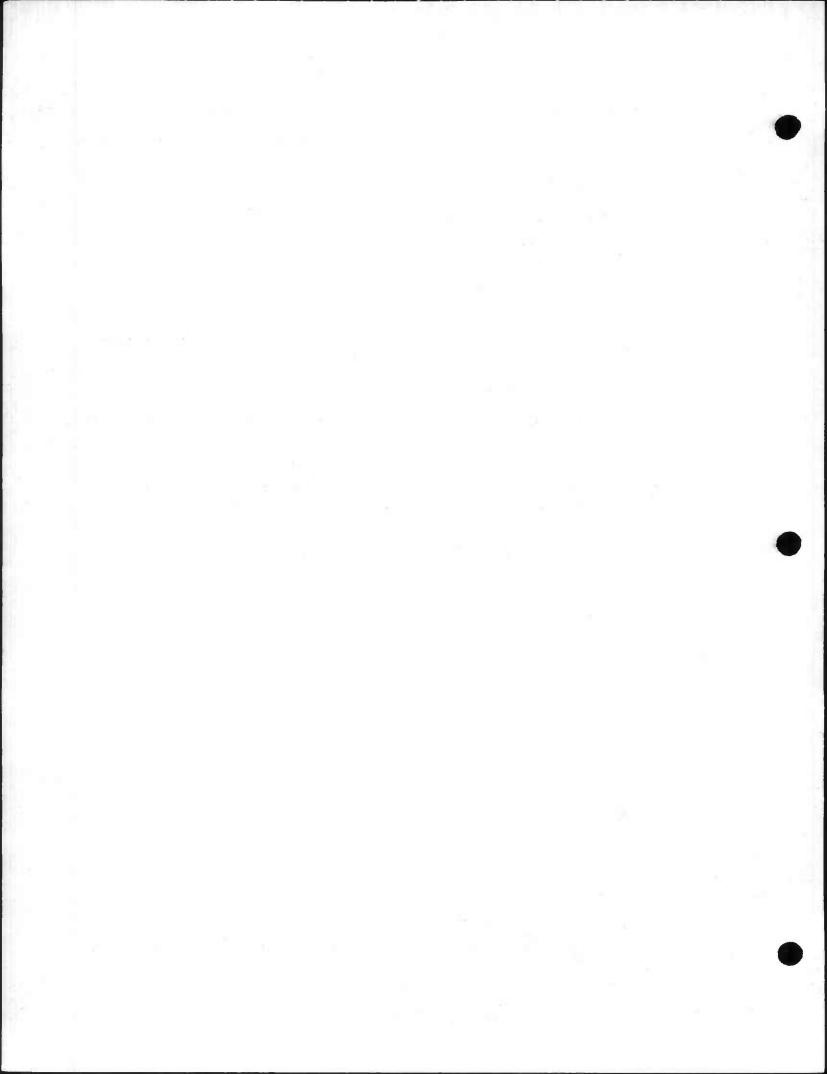
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O

| | Di di | | Decedant's Nama (First, Middle, Les | | aryianu / | Certific | cate of | Death | 2. Data of De | Reg. No. | 1 6 | 3. Tima | 83 |
|--------------------------------|--|----------------|---|--|-------------------|---|---|---|------------------------------------|-----------------------------------|--------------------------------------|--|-----------------|
| | Physici /Medi | | Sandra | | | Re | red | | AUGUST | I3 | 1997 | 18:3 | 33 |
| | Examir | | 4e. Facility Neme (If not Institution, giva | street end number) | | | | 4b. City, Town, or L | ocation of Death | 4c. Count | y of Death | | |
| | Funeral Director | | 101-30-0920 | | a (In yrs. last I | birthdey) If U Mon | | BALTIMORE If Under 24 Hrs. Hours Min. | 8. Date of Bin (Month, Da | th y, Year) 1950 | | placa (State htry) nsylv | a or Foreign |
| | and we | | Usual Rasidance of Dacedani 10a. Stete 10b. County | | 10c. City, To | wn or Location | | | | | 1 | Od inside | City Limits |
| | Mary | ō | Maryland Calvert | | Lust |)V | | | | | | | as 2 No |
| | r 28s | Director | 10e. Street and Number | | 200 | - | . Zip Coda | | | 10g. Citizan of | Whet Cour | ntry? | |
| | h with | a D | 11840 Highview Ci | rcle | | | 20657 | 7 | | U.S. | Α. | | |
| 020 | be filed within 72 hours after death with the Maryland tal hygiene. d other than "natural", or items 23a or 28a-f ehow event, the Medical Examiner trust be notified at | by Funeral | 11. Maritel Status 1 □ Navar Married 2 ☑ Married 3 □ Widowed 4 □ Divorced | 12. Was Decedant & Armed Forcas? 1 ☐ Yas 2 ☑ N If Yas, Giva Yaar or Datas: | | If Yes, | ecedani of h specify Cub as 2½ No | Hispanic Origin? (Sp an, Mexican, Puerto Specify: | pecify Yas or No o Rican, atc.) | | ca - Amaric ack, White, fy: Wh | | |
| 215-0 | nin 72 ho r. n *natur Wedical | Completed | 15. Decedant's Edu (Specify only highast grad Elemantary/Secondery (0-12) | ia complated) | | ia. Decedant's (Giva kind o lifa. DO NO | Usuai Occup I work dona OT usa retire | pation during most of world) | king | 16b. Kind of E | Businass/Ind | dustry | |
| 21 | filed within Hygiene. ther than * | Com | Elemanary/Secondery (0-12) | College (1-4or 5- 2 years | +) | Homem | aker | | | Own : | Home | | |
| Baltimore, Maryland 21215-0020 | should be filed nd Mental Hygie marked other umatic event, II | To Be | 17. Fathar's Nama (First, Middla, Last) Adelbert | John | Richmo | ond | | 18. Molhar's Nam Ruth | ne (First, Middla, Anita | | ma) Ball | | |
| lan | SPES | | 19e. informant's Name/Raletionship (7) | | 19 | 9b. Mailing Add | lrass (Street | end Number or Ru | ral Routa Numbe | er, City or Town | , Stata, Zip | Coda) | - 5 |
| e, | l and lealth m 27 her tr | | Edward John Reed/S | pouse | | | | v Circle, | | | 657 | | |
| 100 | mt of h | | 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ F | | cama | of Disposition tary, cramatory | or othar pla | 1 | Data | 20c. Location | | | |
| Ħ | permit. Pages 1 and 2 Depertment of Health a Important: If Nem 27 Is any Injury or other tra- once. | | 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens | | Metro | polita | | natory | 8/15/97 | Alexa | ndria | , Vir | ginia |
| Ba | Deperiment of the series of th | | mil at | 24 | 0. | Matt | ingley | /-Gardine | | | | | |
| | Physician | | 23a. Part1. Enter the disease, or compi shock or heart failure. List only o | icátions/that caused he ceusa on aach lin | tha daath. Do | P.O. o not antar tha | moda of dylr | 270, Leona ng, such as cardiac | ardtown, or raspiratory ar | Maryl | and : | Approxim Interval B Onset an | nata Batween |
| 1 | /Medical Examiner | | Immediate Causa (Final disaase or condition | Resor | inter | failur | 6 | | | | | 36 h | 011.75 |
| | LAGIIIIICI | _ | resulting in death) | | Dua to (or a) | a consequence | of): | | | | | | |
| | nsit | Examiner | | b | | | | | | | | | |
| Ć, | ificate be executed g physician end es the bunal-transit | Еха | Sequentially list conditions, if any, leeding to immadiata causa. Entar Undarlying Cause (Diseasa or Injury that initieted avants | | Dua to (or as a | a consequence | of): | | | | į | | |
| 68760, | nysicia he bu | edicai | Cause (Diseasa or Injury thet initieted avants rasulling in deeth) Last | C | Due Io (or es a | consaquance | of): | | | | | | |
| | E 00 | | | | | | | | | | i | | |
| Вох | death certif e attending ed for use e | lan | | d | | | | | | | | | |
| P.O. | thet the death cer ed by the attendin detached for use | Physician/M | Part II. Other significant conditions con | ntributing to death bu | it not rasulting | in the underlyi | ng causa giv | an in Part I. | 23b. Did t | obacco use co | ontribute to | the cause | e of death? |
| | signed by | by Ph | | | | | | | 10 | Yes 2 No | 3 Prol | bably 4 | Unknown |
| Records, | peen | Completed b | | | | | | | 24a. Was perfo | an autopsy med? | avi | ara autops: ailebla prio mpletion of deeth? | or to |
| | The page | mo: | | | | | | | 1 🗆 ነ | as 28 No | 10 |]Yas 2 | ⊠ No |
| /ita | ysician: The | Be | 25. Wes casa rafarred to medical exeminar? | | | | | 26. Placa of Deal | th (Check only o | ne) | | | |
| 5 | 5 00 | 2 | 1 ☐ Yas 2 No | Hospital: 1X Inpatiar | | | DOA Oth | 4 □ Nursing H | ome 5□ Resid | | | v) | |
| N N | ling P | ion: | 27. Manner of Daath 1. ■Natural 5 □ Panding | 28a. Data of Injun (Month, Dey | | . Tima of Injury M | 28c. Injur Wor | | 28d. Dascribe h | low injury occu | rred | | |
| Division of Vital | or Attending effer death. Director: After I in by the fune | Certification: | 2 Accidant investigation 3 Sulcide 6 Could not be detarmined | 28a. Placa of Injubuilding, atc. | | | | Yes 2 □ No | 28f. Location (S City or Ton | | ber or Rura | l Routa Nu | umber, |
| | To the Hospital or Attending Ph within 24 hours effect death. To the Funeral Director: After th completely filled in by the funeral | edicai Ce | 29a. Cartifier (Check only one) Certifying Physical Examination (Check only one) | sician: To the bast of ner: On the basis of and mannar stat | axamination a | ge, deeth occur and/or investiga | red at tha tir tion, in my o | ma, data and placa, ppinion, daath occur | and dua to the orred at tha tima, | cause(s) and m data and place, | enner es st , end due to | ated. | a(s) |
| | Mithin Fo the | Me | 29b. Signatura and title of cartifier | n 1 | 1 | | 29c. Licans | a number | | 29d. Date signe | ed (Month, | Dey, Year) |) |
| | 3 | | MANN 1 | up Kesid | lent | | RI | ES-mo | 0 / | Junust 1 | 13.19 | 97 | |
| 1 | () | t | 30. Nema and eddress of person who co | 1114 | eath (Item 23a |) (Type, Print) | | | | 9 |) - | . , | |
| | | | Eric Yeck | theJ | Johns } | topkins | HOSP | ital | Baltim | are, MI |) 2 | 128 | 7 |
| | Sta | te | 31. Data filed (Month, Day, Yaer) | 1997 Augiste | r's Signature | en Rost | U. | | | J | | | , |



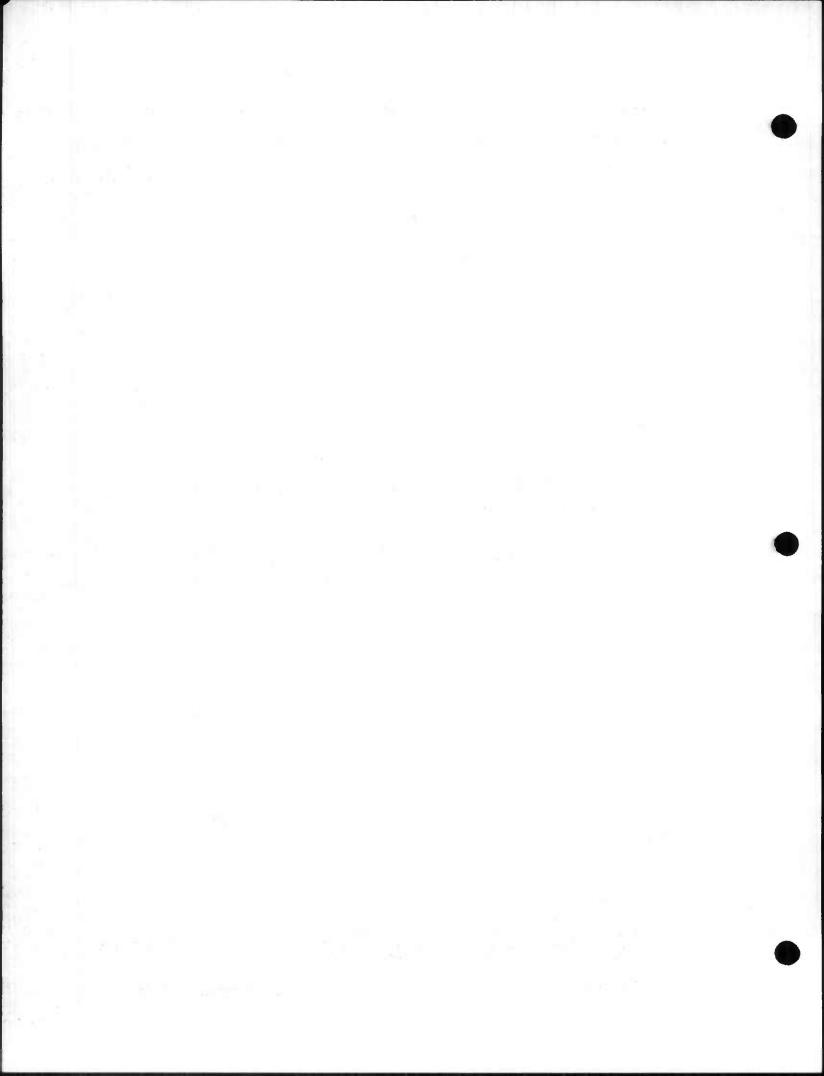
State of Maryland / Department of Health and Mental Hygiene 97 27084

| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death 1 ves 2 ves 3 Probably 4 Unknow 24b. Were autopsy findings performed? 24b. Were autopsy fi | | | | | | | Uei | lilicate of | Dealli | | Reg. No. | | |
|--|--|---------|---------------------------------------|-------------------------|----------------------------|----------------------|-------------------|---------------------|-----------------------|------------------|-------------------------|--------------|-----------------------|
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| Usual Payaboration of Decedant 10.0 state City Limits 10.0 state | | | 220-16-7 | 878 | 1 □ M 2 🗓 F | 7.1 | Yrs. | Months Days | Hours Min. | | | | |
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| Elementary Transcributing (0-12) College (1-4or 5-) College (1-4or | or the contract | 5 | 1 ☐ Never Ma | rried 2 Marrie | d 1 ☐ Yes | 2 K No | | | | Hican, etc.) | Ble | ck, White, | etc. |
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| 19 | | i i | | ecify only highest | grade completed) |) | (Give | kind of work done | during most of work | Ing | | | |
| 19 | then the | E | | condary (0-12) | Collega (| (1-4or 5+) | | | 50) | | | | |
| Second Companies Physician | led lygis | ပိ | | are a series of | | | Cle | rical | T | | | | |
| P.O. Box. 270, Leonardtown, MD 20650 20a Part, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interest Between Chest and Death Approximate Interest Between Chest and Death Immediate Cause (Final disease) or conditions. Interest Between Chest and Death Dus to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death | D d d d d d d d d d d d d d d d d d d d | Be | 17. Famars Nama | a (First, Middle, Li | ast) | | | | 18. Mothers Nam | e (First, Middle | , Ma <i>idan Sum</i> an | 10) | |
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| P.O. Box. 270, Leonardtown, MD 20650 20a Part, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interest Between Chest and Death Approximate Interest Between Chest and Death Immediate Cause (Final disease) or conditions. Interest Between Chest and Death Dus to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death | M nd 2 | | Sharo | n L. Rya | n/Daught | er | 14 | 78 01d 0 | ak Arch, | Virgini | a Beach | , VA | 23456 |
| P.O. Box. 270, Leonardtown, MD 20650 20a Part, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interest Between Chest and Death Approximate Interest Between Chest and Death Immediate Cause (Final disease) or conditions. Interest Between Chest and Death Dus to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death | Ghang Hang | | 20a. Method of Di | sposition | | 20b. Pl | 4 | | | 7 | | | |
| P.O. Box. 270, Leonardtown, MD 20650 20a Part, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interest Between Chest and Death Approximate Interest Between Chest and Death Immediate Cause (Final disease) or conditions. Interest Between Chest and Death Dus to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part III. Other significant conditions contributing to death | Or H H | | | | | State | | | | 8/19/97 | | | |
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| State Stat | ysic Is ca | | | No | Hospital: | Inpatient 2 E | ER/Outpatien | t 3 DOA O | ther: 4 Nursing Ho | me 5 Resi | denca 8 □Oth | nar (Specif | (v) |
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State of Maryland / Department of Health and Mental Hygiene 97 27085

| | | | | | | Ce | rtificat | e of | Death | | Re | eg. No. | • | |
|---------------------|---|----------------|---|-----------------------|---|--|---------------|----------------|----------------|-----------|------------------------------------|----------------|--------------|--|
| | -11 1. | | 1. Decedent's Name (First, Middle | , Last) | | | | | | | 2. Date of Deat | h | | 3. Time of Death |
| | Physic | | Bertha | N 21. | nine | D17= | n | | | | Month | Day | Year | 7 00 |
| N | /Medi | | 4a. Facility Neme (If not institution | | aine | Rya | 111 | | 4h City To | wn orlo | Aug 24 ocation of Death | 4c. County | * | 7:00 |
| ч | Exami | ner | 22003 Point | E | | | | | | | | | | |
| Н | | | | | + | and the same to be delivery | If Under | 1 Voor | | narc | ltown | St. | Mar | |
| н | Funeral | | 5. Social Security Number | 6. Sex 1 ☐ M 2 ဩ F | | s. lest birthdey Yrs. | Months | Deys | | Min. | 8. Date of Birth (Month, Day, | Year) | 9. Birthp | place (Stete or Forei |
| | Director | 1 | 178-18-8002 | | 11 | 115. | | | | | Dec. 29 | ,1919 | Ma | aryland |
| | p | | Usual Residence of Decedent 10a. State 10b. County | | 100.0 | City, Town or L | ocetion | | | | | | | 104 124- 01121 |
| | ah o | - | | | | | | | | | | | - [| 10d. Inside City Limi 1 ☐ Yes 2 🖾 N |
| | Be-f | oto | | ary | Le | onardt | own | | | | | | | I∐ Yes Z⊠N |
| | # 9 P | Director | 10e. Street and Number | | | | 10f. Zip | Coda | | | 10 | Og. Citizen of | What Cour | ntry? |
| | 15 w | <u>a</u> | 22003 Poin | t Lookou | it Road | | | 206 | 550 | | | USA | | |
| | n 72 hours after deeth with the Maryland "natural", or Items 23a or 28s-f show solical Examiner must be norified at | Funeral | 11. Marital Status | 12. Was De | ecedent Ever in | U,S. 13. | Was Deced | dent of | Hispanic Ori | gin? (Sp | ecify Yes or No- Rican, etc.) | 14. Rac | ce - Americ | |
| 0 | or he | F | 1 Never Married 2 Marri | ed 1 ☐ Ye | Forces? s 2 ☑ No | | | | | | Hican, etc.) | Bia | ck, White, | |
| 020 | urs a | by | 3 Nidowed 4 Divorced | If Yes, 9 | Give T | | 1□ Yes 2 | 2X No | Specify: | | | Specif | y: Wh | nite |
| ŏ | 2 ho | P | 15. Decedant | 's Education | - | 16a. Dece | dant's Usua | I Occu | nation | | | 16b. Kind of B | usinass/In | dustry |
| 13 | be filed within 72 ho ttal Hygiene. Id other than "netur event, the Medical | Completed | (Specify only highes | t grade complete | | (Give | kind of wor | rk done | during mos. | t of work | ing | | 001110001111 | |
| 2 | e filed within al Hygiene. other than " | Ĕ | Elementary/Secondary (0-12) | College | (1-4or 5+) | | | | | | | | | |
| 0 | Hygie Hygie | | 17. Father's Name (First, Middla, I | act) | | | lomema | iker | | r'e Name | e (First, Middle, N | | n_Hon | ne |
| Maryland 21215-0020 | should be ind Mental I | Be | | | oodburn | | | | | | | | | |
| Ž | should b nd Menta marked | 2 | | | ooaburn | L | | | Ве | rtha | Ann | S | tone | |
| ā | C/ co Ti co | | 19a. Informant's Name/Ralationsh | ip (Type, Print) | | 19b. Mail | ing Address | (Straa | t and Numbe | er or Run | al Route Number, | City or Town, | , Stete, Zip | Code) |
| | other tra | | Henry A. Rya | n/Son | | 109 | Clam | nar | Ave. | Hav | ertown, | PA 190 | 83 | |
| or e | of He | | 20a. Method of Disposition | | | Place of Disponentary, cre | osition (Nen | ne of | | | Date 2 | 20c. Location | | own, State |
| Baltimore, | Pages nent of i wrt: If its ury or o | | 1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sc | | | oly Fac | • | | , | | 8/27/97 | Crost | M:11 | G MD |
| | 글로본글 . | | 21. Signature of Funeral Service L | | | | | | ess of Facilit | | 0/2/// | Great | TILLI | .5, 110 |
| B | Depa Impo any i | | 60 1 1 | 1/4 | 1 | M | attino | gle | v-Gard | iner | Funeral | Home. | P.A | |
| | | | 23a. Part 1. Enter the disease, or | Sar | dene | P | .O. Bo | ox 2 | 270. L | eona | rdtown. | Maryla | and 1 | |
| | | | 23a. Part1. Enter the disease, or shock or heart failure. List of | complications that | t caused the de | ath. Do not en | ter the mode | e of dy | ing, such as | cardiac o | or respiratory arre | st, | | 20650 Approximate Interval Between |
| | Physician | | | | _ | | 1 | | 0 | | | | - 1 | Onset and Death |
| d. | /Medical | | Immediate Causa (Final | | 1. | On a | Do | 10 | K | | P | | | Mr X |
| | Examiner | П | disease or condition resulting in death) | a. () | uad | cen | Dec. | 7 | - | 12 | rov. o | cur | 2 / | · · · · · · · · · · · · · · · · · · · |
| | | ē | | | Due to | (or as a conse | quenca of): | 1 | nonz | | Auf | int | 2000 | Minne |
| | pet is | Examiner | | b | | | | | / | | | | | 7201 |
| | and I-trar | xar | Sequentially list conditions, if any, leading to immediate | | Dua to | (or as a conse | quence of): | | | | | | 1 | |
| 60, | cian cian | | Cause. Enter Underlying Causa (Disease or Injury | c | | | | | | | | | 1 | |
| 68760, | ertificeta be axecuted ding physician and sa as the buriel-transit | edical | that initiated avants resulting in death) Last | 0 | Due to | (or as a consec | quenca of): | | | | | | i | |
| 9 × | ng p | Me | | | | | | | | | | | 1 | |
| 0 | eath certif attending for use a | an | | d | | | | | | | | | | |
| 00 | 0 0 | Physician | Part II. Other significant condition | s contributing to | death but not re | sulting in the I | ınderivina cı | ause ni | ven in Part I | | 23b Did tol | DACCO USA CO | ntribute to | the cause of deat |
| 0 | tha by th | hys | | | | Journal of the Control of the Contro | indonying or | aaoo g | | | . — | _ | | |
| ٣ | thet hed b | | | | | | | | | | 184 | 8 2□ No | 3 Prot | bably 4 ☐ Unkno |
| ds, | w requiras thet been signed I should be det | d by | | | | | | | | | 04- 144 | 1 | 245 146 | oro autopou findinos |
| 0 | requ houl | ete | | | | | | | | | 24a. Was ar perform | | ava | ere autopsy findings ailable prior to |
| Record | 20 CV | Completed | | | | | | | | | | | | mpletion of cause death? |
| | 0 - 5 | ОП | | | | | | | | | 1□ Ye | s 20 No | 10 | ☐Yes 2☐ No |
| VIII VIII | lclan: The certificate rector, pag | Be C | 25. Was casa raferred to medical | | | | | - | 26 Place | of Dont | (Check only one | - | | |
| | | | examiner? 1 ☐ Yes 2 ☐ No | Hospital: | 71 | 7 ED/0 | | . Ot | her: | | | 1 | | |
| ō | Phys this rai d | - L | 27. Mannar of Death | | Inpatient 2[a of Injury | ☐ ER/Outpatie | | A | 4 U Nu | - | me 5 Beside 28d. Describe ho | | | Y) |
| ב | | ion | 1 Sectural 5 ☐ Pending | (Mc | onth, Day Year) | Injury | | 8c. Inju Wo | | | 26d. Describe no | w injury occur | reu | |
| Division | Attending or death. | Certification: | 2 Accidant Investig | ot be | | | М | | Yes 2□I | No | | | | |
| ≥ | or Attendate date date date date date date date | E I | 4 Homicida determi | ned Zoa. Fla | ce of Injury - At Iding, atc. (Spec | home, farm, st | raat, factory | , office | | | 28f. Location (Str City or Town | | per or Rura | / Route Number, |
| | To the Hospital or Attent within 24 hours after daat To the Funeral Director: completely filled in by tha | | | | | | | | | | | | | |
| | hou | - a | 29a. Cartifiar 1 Oertifying | Physician: To the | ne best of my kr | nowledge, deat | h occurred a | at the ti | me, data an | d place, | and dua to the ca | use(s) and ma | anner as si | tated. |
| | n 24 n 24 ne Fi | edical | one) | and ma | basis of examination of the control | nation and/or in | vestigation, | in my | opinion, daal | th occurr | ed at the time, da | ta and place, | and due to | the causa(s) |
| | Vithi To the | Σ | 29b. Signature and title of certifies | 0/0 | 1 | | 29c | . Licen | se number | | 29 | d. Date signe | d (Month, | Dey, Year) |
| | ->-0 | | 10 | 118 | 2 | 1 | 0 | 1- | ردا د | 31 |) | 8/5 | -/ | |
| | | 1 | , de | 1// | ~ | 1.0 | 1 | 11 | ~ ~ | ں رہ | | 0/2 | 1 / 2 | |
| | | | 30. Nama and address of person v | no completed ta | use of daath (Ita | am 23a) (Type, | Print) | | | | | / | 1 | |
| | | | David Allen, N | I.D. | | | | Cal | iforni | a N | Maryland | 20619 |) | |
| | Sta | ite | 31. Date filed (Month Day, 726) | 1007 32. | Degistrar's Sign | natura | | JUL. | | ~ 1° | MI YIANG | -0019 | , | |
| | Registr | ar | חטע הס | 1997 | Alex alkers | yor Kard | U | | | | | | | |



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** Catherine Drucile RUBLE August 25, 1997 5:00 AM /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 21413 Ruble Road Boonsboro Washington 5. Social Security Number If Undar 1 Yaar If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🕱 F 212-38-9526 Yrs. Director 96 March 6,1901 Maryland Usual Rasidance of Decedant the Maryland 10a. Stata 10c. City, Town or Location 10b. County 10d. Inaida City Limits item 27 is marked other than "natural", or itema 23a or 28a-f ehow other traumatic event, the Medical Examinar must be notified at 1 ☐ Yas 2 1 No Director Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? with 21413 Ruble Road 21713 USA permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: if flem 27 is marked other than "netural", or flems 23s any injury or other traumatic avant Funeral 12. Was Decedant Evar In U,S. Armed Forcaa? Was Dacedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - American Indian, Black, Whita, atc. 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 ☐ Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify. þ Specify: white 3 X Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) homemaker her own home 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Sumame) Clarence A. Cosens, Sr. Emma Katherine Harman 19a. tnforment's Name/Raletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Jane D. Faulder - niece 21441 Ruble Rd., Boonsbors, Md. 21713 20b. Placa of Disposition (Name of cemetery, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from State 4 ☐ Donetlon 5 ☐ Othar (Specify) Rose Hill Cemetery 8-28-97 Hagerstown, Maryland 21. Signature of Funeral Sarvica Licenses 22. Nama and Addrass of Facility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Entar tha disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Onsat and Death **Physician** /Medical Immediate Causa (Final Un Known diseasa or condition rasulting in daath) Examiner Dua to (or as a consequence of) Examiner burial-transit Sequentially list conditions, if any, leading to Immadiate causa. Enter Underlying Causa (Disease or Injury that initiated events pue Dua to (or as a consequence of): physician s the burial Box 68760. Physician/Medical that initiated evants resulting in death) Last Dua to (or as a consequence of) nse. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 No 3 Probably 4 Unknown trial Fibrillation b 24b. Ware autopsy findings available prior to completion of causa of deeth? 24a. Was an autopsy performed? Completed peed Stepartheto cate hes t this certificate 1 Yas 1 ☐ Yea 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.
To the Funnet Director: After this certifica completely filled in by the funeral director, Be 25. Was casa rafarred to medical 28. Placa of Death (Check only ona) axaminar? Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Homa 5 ☐ Plasidanca 6 ☐ Other (Specify) 1 Yas 2 No 2 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how Injury occurred Certification: 28b. Tima of 5 Panding 1 Natural 1 Yas 2 No Invastigation 2 Accidant 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 - Homicida 29a. Cartifian 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicat Examiner: On the basis of exemination and/or invastigation, in my opinion, death occurred at the time, deta and piece, and due to the cause(s) and manner stated. 29b. Signatura and titla of cartifian 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Nama and eddrass of person who complated cause of daeth (Item 23a) (Type, Print) 22911 Jefferson Blyd Smiths byrg had

erns

32 Ragistrar's Signatura

Ausa Davidson

State Registrar 31. Data filed (Month, Dev. AUG 26

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in the second

State of Maryland / Department of Health and Mental Hygiene 97

| | | | | | | Certificate | e of | Death | | F | Reg. No. | , , | 21001 |
|-------------|---|----------------|---|--|-----------------------------|---|-------------------------------|--------------------------------|-------------------------|--|----------------------------------|-------------------------|--|
| | Db | | 1. Decedent's Name (First, Middle, Las | t) | | | | | | 2. Date of Dea | ith | | 3. Time of Deeth |
| | Physic /Medi | | Theron Kenne | th Rinehar | t | | | | | August | 24, 19 | 997 | 8:37 P. M. |
| | Exami | | 4a. Facility Name (If not institution, give | | | | | 4b. City, To | wn, or Lo | cation of Death | 4c. Count | y of Death | |
| L | | | 819 Forest Dr | | | | | Hager | stow | n | Wash | ningt | on |
| | _o Funeral Director | | 5. Social Security Number 6. Security Number 220–16–2875 Usual Residence of Decedent | 7. Age (In 72 72 | n yrs. lest birti | hday) if Under Months | 1 Yaar Days | Hours | 24 Hrs. Min. | 8. Data of Birth (Month, Pay Oct. 12 | , Yaar) , 1924 | 9. Birth Cou Mary | nplaca (Steta or Foreign untry) y Land |
| | Maryland at show filed at | tor | 10a. Stata 10b. County Maryland Washir | | c. City, Town Hage | or Location Prstown | | | | | | | 10d. Inside City Limits 12 Yes 2 □ No |
| | th with the 23s or 28 ast be not | al Director | 10e. Street and Number 819 Forest Dr | ive | -,, - | 10f. Zip | | 740 | | | 10g. Citizen of USA | What Cou | untry? |
| 020 | hours after death with the Maryla tural', or items 23a or 28a-f show all Examiner must be notified at | by Funeral | 11. Maritai Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ever Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Datas: | in U,S. VW2 | 13. Was Decedent Yas, special 1 Yes 2 | | | gin? (Spe , Puerto f | cify Yes or No- Ricen, atc.) | 14. Ra Bla Specil | ck, White | icen Indian, , etc. iite |
| 21215-0020 | within 72 hy nns. Then "natus te Medical | Completed | 15. Decedent's Ed (Specify only highest grad Elementery/Secondary (0-12) | ucetion de completed) Coilege (1-4or 5+) | 18a. i | Decedent's Usue (Give kind of won life. DO NOT us | l Occup k done e retire | pation during most d) | of working | ng | 16b. Kind of B | lusiness/le | ndustry |
| 2 | 2 0 4 4 2 4 4 4 | Col | | 4 | Pu | blic Rel | ati | ons 0 | ffice | er | Fairchi | .ld A | ircraft |
| pu | E figh | Be | 17. Fathar's Name (First, Middle, Last) | | | | | | | (First, Middle, | | ne) | |
| 충 | Man Marka Marka Marka | 10 | Bruce Theron Ri | | | | | Kath | , | Hars | | | |
| e, Maryland | and 2 sh eaith and m 27 is m | | Jeannett K. Rine | nart | 81 | Malling Address 9 Forest | : Dr | ive l | Hage | rstown, | r, City or Town Maryla | , Stete, Zi and 2 | ip Code) 1742 |
| Baltimore | Pages 1 nent of H ant: if Ner ury or oth | | 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify, | Removal from State | | Disposition (Nem crematory or of aVEN CEII | | ce) Ly | 8/3 | 27/97 F | 20c. Location lagers to | OWN, | own, Stata Maryland |
| Balt | Depart Import any inj once. | | 21. Signature of Funeral Service Licens | nunc | h | Gerald Funera | | | ch | | Potom | | treet land 21740 |
| | | | 23a. Part1. Enter the disaase, or comp shock, or heart feilure. List only o | ications that ceusad tha | death. Do no | ot antar tha mode | of dyi | ng, such as | cerdiac o | | | | Approximata tntervel Between |
| | Physician /Medical Examiner | | Immediate Cause (Final disease or condition resulting in death) | Λ | 101 | 0851 | 5 | | | | | | Onset and Death YEAZS. |
| | 9 9 | Examiner | _ | CERE | BRA | on equence of): | 10 | UM | 2 | Decil | ENS | - | Typ |
| o, | cate be executed physician and the burial-transit | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | 1410H | to (or es e co | onsequence of): | NE | | | | | | 1,524 |
| x 68760, | erificate be ling physicia is as the bur | Medical | Cause (Disease or injury that initiated events resulting in death) Last | Due | to (or as a co | onsequence of): | | | | | | | 9:40 |
| 80 | death or a stiend of for us | | | | | | | | | | | 1 | |
| P.0. | that the d ed by the detached | Phy | Part II, Other significant conditions con | ntributing to death but no | t resulting h | the underlying ce | use giv | ven in Part I. | | 23b. Did to | ss 2 No | | to the cause of death? |
| Records, | s law requires has been sign pe 2 should be | Completed by | | | | | | | | 24a. Was a perfor | n autopsy med? | a\ cc | Vere autopsy findings vailabla prior to ompletion of ceuse f death? |
| | cate h | Com | | | | | | | | 1□ Y | es 2 10 No | 1 | ☐ Yes 2☐ No |
| VItal | antitlo sctor, | Be (| 25. Was case referred to medical examiner? | | | | | 28. Plece | of Death | (Check only or | 10) | | |
| 6 | Physician: this certific ral director, | 2 | 1□ Yes 2⊡rNo | | 2 ER/Outp | | | 4 LI NUI | rsing Hom | ne 5 D Aeside | ence 6 🗆 Oth | er (Speci | ify) |
| Ĕ | | ion | 27. Manner of Death 1 ☑ Matural 5 ☐ Pending | 28e. Date of Injury (Month, Dey Yea | 28b. Tir | | kc. Injur Wor | | | 8d. Describe h | ow injury occur | red | |
| DIVISION | al or Attending to after death. al Director: Alte ed in by the fund | Certification: | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined | 28e. Place of Injury - building, etc. (Sp | At home, farm | n, street, factory, | | Yes 2□N | | 8f. Location (Si City or Town | traet end Numb n, Stete) | oer or Rur | al Route Number, |
| | To the Hospital or within 24 hours afti Within 24 hours afti To the Funeral Dir completely filled in | edical | 29a. Certifler Certifying Physical Cardinal Cardinal Cardinal Examination (Check ant) | elcien: To the test of my ner: On the basis of exar and manner stated. | knowledge, mination and/ | deeth occurred a for investigation, i | t the tir | me, date and opinion, deati | place, ar h occurre | nd due to the co | ause(s) and me ate and place, | and due t | stated. to the cause(s) |
|) | To the within 2 To the complet | M | 29b. Signature and the of certifier | to W | SOST | W | Licens | 22 (| 14 | 3 2 | 9d. Data sign | 201 | 97 |
| | | | 30. Name and address of person who co | mpleted cause of death | (Item 23e) (T | ype, Print) | 300 | 10 | | | Hage | rsta | WM, MD 174 |
| | Sta | te | 31. Dete filed (Month, Day, Xea) | 32. Registraris S | ignature | 10 IVICA | ica | 1 (| ump | ius x | in our | 10 1: | 50 |

* . . . 45 O.A.

State of Maryland / Department of Health and Mental Hygiene 97 27088

| | | | | | | Cer | tificate of | Death | | | Reg. No. | | |
|-------------------|---|----------------|---|---|---------------------------|--------------------------|--|-----------------------------|--------------------------|---|----------------------------------|---------------------------|---|
| | Dhool | ion | 1. Decedent's Name (First, Middle, La | st) | | | | | | 2. Dele of De Month | | Vaar | 3. Time of Deeth |
| | Physic /Medi | | Irvine Ha | rt Rutle | edge | | | | | August | | 1997 | 0036 |
| | Exami | | 4a. Fecility Name (If not institution, giv | re street and number) | | | | 4b. City, To | | callon of Death | 1 | y of Deeth | |
| | | | Washington Cou | nty Hospi | ital | | | Hage | erst | own | Wash | ingto | on |
| | _o Funeral Director | | 5. Social Security Number 6. S 5 7 8 0 9 6 9 9 6 9 9 6 Usuai Residence of Decedent | Sex 7. Age I⊠M 2□F 8. | (In yrs. last | birthdey) Yrs. | If Under 1 Yeer Months Days | | Min | 8. Date of Bird (Month, Da June 23, | v. Year) | 9. Birthp Cour Peni | olece (State or Foreign ntry) NSylvania |
| | yland | | 10e. Stele 10b. County | | 10c. City, To | own or Lo | cation | | | | | 1 | 0d. Inside City Limits |
| | Man | to | Maryland Washin | gton | Hage | rsto | own | | | | | | 1 ☐ Yes 2 ☒ No |
| | th the | Director | 10e. Street and Number | | | | 10f. Zip Code | | | | 10g. Citizen of | What Cour | ntry? |
| | ter death with the Marylan ferms 23a or 28a-f show free must be notified at | | 19010 Orchard | Terrace I | Road | | 21742 | | | | USA | | |
| | r dea | Funeral | 11. Marital Status | 12. Wes Decedent E Armed Forces? | ver in U,S. | 13. V | Vas Decedent of Yes, specify Cut | Hispanic Ori | igin? (Spe | cify Yes or No | 14. Ra | ce - Americ | |
| 0050 | al', or | by | 1 Never Married 2 Married 3 Widowed 4 Divorced | 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates:W | | | ☐ Yes 2√ No | | | | | w Whi | |
| 21215-0020 | within 72 ho ene. than "natur | Completed | 15. Decedent's Ed (Specify only highest gra Eiementary/Secondary (0-12) | ducation ide completed) College (1-4or 5- | | (Give | ent's Usuai Occu kind of work done OO NOT use retire | during mos | t of worki | ng | 16b. Kind of E | Business/Ind | dustry |
| 2 | 77 75 1- | S | | 5 + | | Judg | ge | | | | La | | |
| and | B B B | Be | 17. Father's Name (First, Middle, Last, | | | | | | | | Maiden Sume | | |
| 2 | should be ind Mental marked o | 1º | | | ıtled | 0 | | | ren | | uise | Hart | |
| , Maryland | d 2 strauth and traut | | 19e. Inlormant's Name/Relationship (Jeanette Rutle | | 1 | 9010 | | rd Te | er or Rura | ce Rd. | Hage: | rstate, Zip | wn, Md.21 |
| altimore, | Pages 1 nent of H int: if Itan iny or oth | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif. | | | | sition (Name of letory or other place). 11 Cem | | 7 8 | Date / 23/97 | Hage: | | wn, Slete wn, Md. |
| Balti | permit. Pages 1 an Department of Heal Important: if Itam 2 any Injury or other once. | | 21 Sign ture of Funeral Service Licar | | R | G e | Name and Addr rald N ineral | ess of Facilit | hv | h 3 | 805 N. | Poto | omac St. , Marylan |
| | Physician /Medical | | 23a. Fert1. Enter the disease, or com shock, or heert failure. List only | plications that caused to one cause on each line | the death. D | | | | cardiac o | r respiratory ar | rest, | 1 | Approximete Interval Between Onset end Deeth |
| | Examiner | | disease or condition resulting in death) | a. Cardio | Pulmo | nary | FAILURE | | | | | 3 | 6-24 hours |
| | | ē | | | Due to (or as | | | | | | | | |
| | betu 3 ansit | 듄 | | b. Arterios | | | | sease | | | | | years |
| o, | exection and and rial-tra | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | U | ue to (or as | a consequ | Jence of): | | | | | | |
| 68760, | ysicia | edical | that initieted events | c | ue to (or as | a consequ | ienca of): | | | | | | |
| Box 68 | aath certificate be executed attending physician and for use as the burial-transit | 2 | resulting in death) Last | d | | , | | | | | | | |
| O. | that the death red by the atter deteched for u | Physician | Part II. Other significant conditions of | ontributing to death but | not resulting | g in the un | derlying cause gi | ven in Pert I | | 23b. Dld t | obacco usa co | ontribute to | the cause of death? |
| <u>م</u> | at the | Phy | Appendicitis w | th Parfore | tion | | | | | 10 | res 2 No | 3 □ Prot | bably 4 Unknown |
| ທົ | 8 5 8 | by | Appendicies w. | itil Tellola | 161011 | | | | | | | | |
| Record | aw requires that the death is been signed by the atter 2 should be detached for t | Completed | 3 | | | | | | | 24e. Was perfo | an autopsy med? | ava | ere autopsy findings allable prior to mpletion of cause death? |
| | The law ate has b | E | | | | | | | | 101 | es 2KKNo | 10 | Yes 2□No |
| ta | | Bec | 25. Was case referred to medical | | | | | 26. Place | of Death | (Check only o | ne) | 1 | |
| > | 0 0 | To | examiner? 1 ☐ Yes 2 ☒ No | Hospitai: 1 🖾 Inpatient | 1 2 ER/0 | Outpetient | 3 DOA Ot | her: | | | ence 6 Ott | ner (Specify | () |
| Division of Vital | Attanding Ph or death. ector: Aftar th by the funeral | | 27. Manner of Deeth 142 Natural 5 Pending 2 Accident Investigation | 28a. Date of Injury (Month, Dey | Year) 28b | . Time of Injury | 28c. Inju Wo M 1 | ry at rk?] Yes 2 □ l | | 8d. Describe h | ow Injury occu | rred | |
| Divis | al or Attanding s after death. I Director: Aftar of in by the fune | Certification: | 3 Suicide 6 Could not be determined | 28e. Pleca of Injur building, etc. | y - At home, (Specify) | farm, stre | et, lactory, office | | 2 | 8f. Location (S City or Tow | itreet end Num n, State) | ber or Rura | ! Route Number, |
| | To the Hospital or Att within 24 hours after d To the Funeral Direct complately filled in by | edicai (| 29a. Certifier (Check only one) 1 ☐ Certifying Phyone) 2 ☐ Medical Example 1 | valcian: To the best of liner: On the basis of e and manner state | examination a | ge, death and/or inve | occurred et the ti estigation, in my o | me, date an | d piece, e th occurre | nd due to the o | ause(s) end m dete and place, | anner as st and due to | ated. the cause(s) |
| | To the To the Com | Σ | 29b. Signature and litie of certilier | | | | 29c. Licens | se number | | | 29d. Date signe | ed (Month, I | Day, Year) |
| | | | I dever l'e | 2) Hou | - | | DO1 | 062 | | | August | 22, 1 | 997 |
| | | | 30. Name end eddress of person who | completed cause of dea | ath (Item 23e | (Type, F | Print) | | | | | | |
| | | | Edward W. Ditto, | | | 7 W. | Washing | ton St | . Н | lagerst | own, M | D 21 | 740 |
| | Sta | | 31. Date filed (Month, Day, Year) | 32. Registrar | 's Signature | 0 - | | | | | | | |
| | Registr | ar | AUG 2 2 1997 | July Du | MdSon-P | andell | 2 | | | | | | |

DHMH 16 Rav 6/95

1. 1-1. -- ---

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Day Vaar **Physician** 1859 Luther Sutton August 24 1997 /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 8. Data of Birth (Month, Dey, Year)
June 25 1933 Maryland If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplece (State or Foreign Country) Months 1 M 2 F 217-28-3791 64 Usuel Residence of Decedant 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland Wicomico Salisbury 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 28738 Ocean Gateway 21801 U.S.A Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, atc.) 11. Maritel Status 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☐ No þ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 18e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Laborer None 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surname) Be Lee Sutton Mary Mackey ္က 19a. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Earl J.Sutton 28738 Ocean Gateway Salisbury, Md. 21801 20b. Pleca of Disposition (Name of cematary, crematory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burlal 2 ☐ Cremetion 3 ☐ Removel from State 4 □ Donetlon 5 □ Other (Specify) Md. Eastern Shore, VA Hurlock, Md. 21. Signature of Funerel Sarvice Licensee 22. Nama and Addrass of Fecility Stewart Funeral Home
821 West Rd.Salisbury, Md.21801
23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one ceuse on each line. Approximate Interval Between Onset end Deeth Immediete Cause (Final diseese or condition resulting in deeth) Due to (or es e consequenca of): Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events rasulting in death) Lest Due to (or es e consequence of): Dua to (or as a consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of geath? 1 Yee 2 No 3 Probably 4 Unknown failure þ 24b. Were autopsy findings available prior to completion of causa of death? 24e. Wes an eutopsy performed? Completed 1 Yes 2 No 1 TYes 2 No Be 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Menger of Deeth 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No invastigation 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 28e. Plece of injury - At home, farm, street, fectory, office building, etc. (Spacify) 4 Homicide 29e. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of axamination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated. 29d. Data signed (Month, Day, Year) 29b. Signeture end Utilian certifier 29c. Licansa number

D 41721

DR. 8161

8/24/97

DAlishuy, md 21801

filled in by hours 6 24 hours e Hospital Medical completely within 2 0 worde

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Luther Sutton

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If Hem 27 is marked other than "natural" ~ 2.000.000.

Physician

/Medical Examiner

ettending physician and for use as the burial-transit

signed by the

page 2 s certificate has

funeral director.

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After

death.

ofter death Director: /

State Registrar Stephan

Haylos 31. Date filed (Month, Day, Year) AUG 26 1997

Kiverside 32. Registrer's Signature whi divideor hardall

mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death **Physician** Hug Edgar Thomas Stotler
4a. Facility Name (If not institution, give street end /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Sociel Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Days 1⊠M 2□F Director 216-14-6833 Yrs. Feb. 11, 1924 Maryland Usuel Residance of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f sho traumetic event, the Medical Examiner must be notified at Maryland Washington Boonsboro 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 17210 Bakersville Road 21713 USA Funeral 12. Wes Decedent Evar in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - Amarican Indien, Bleck, White, atc. 1 Never Merried 2 Married 1 TYes 2 No If Yes, Give W Yaer or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) permit, Pages 1 and 2 should be filed v. Department of Health and Mental Hygies Important: if them 27 is marked other th any injury or other transmission. Mechanic Trucking 17. Fethar's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Charles Lauren Stotler Anna Rudisill 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Harry L. Stotler 16044 Natural Well Road Williamsport, Maryland 21795 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cramation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Smithsburg Crematory 8/28/97 Smithsburg, Maryland Syneture of Funerel Service Licensee 22. Name end Address of Fecility Gerald N. Minnich 305 N. Potomac Street Funeral Home Hagerstown, Maryland 23e. Pert1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Physician/Medical Due to (or es e consequance of). Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evellable prior to completion of cause of deeth? Mellitus 24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No Division of Vital ä 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 1 Dumpatient 2 ER/Outpatient 3 DOA 2 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? Attor Attending 1 Maturel 5 Pending ours after dea. 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital o within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) and menner steted. Medical 29e. Certifier 29c License number 29b. Signeture end title of certifier 29d. Date signed (Month, Dey, Yeer) M--1

Registrar

State

12821-OAKHILL AVE. HAGERSTOWN. ABDUL WHITEED, MID-31. Dete filed (Month, Day, Yeer) 32. Registrer's Signatura AUG 281997 Junia Davidson

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 97 27091

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| 17. Fathar's Nama (First, Middla, Last) Joseph Sacchet | | . Zip Code 2174 | | | | 10g. Citizan USA | of What Co | untry? |
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| 17. Fathar's Nama (First, Middla, Last) Joseph Sacchet | | | ired) | | | Mo | dicin | 20 |
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| 25. Was casa rafarrad to medical axaminar? 1 | | | | | 10 | Yas 2 No | | 1 ☐ Yas 2 ☐ I |
| 1 Inpatiant 2 ER/Outpa | | | 26. Piac | e of Deatl | h (Check only | one) | | |
| | ent 3□ | DOA | | ursing Ho | ma 5 🗓 Ras | idance 6 🗆 | Othar (Spec | cify) |
| 2 Accident Invastigation | of M | 28c, In W | juryat /ork? □Yas 2 □ | | 28d. Dascribe | how Injury oc | curred | |
| building, atc. (Spacify) | raat, fac | otory, offic | ө | | | (Straat and Nu wn, Stata) | mber or Ru | ral Route Numb |
| 29a. Cartifier (Check only street) 29a. Cartifier (Check only street) 4 Certifying Phyelcian: To the best of my knowledge, day and manner stated. | th occurr westigat | red at tha tion, in my | tima, data ar opinion, des | nd place, oth occurr | and dua to tha ed at the time, | causa(s) and date and place | mannar as e, and dua | stated. to the cause(s) |
| ■ Spb. Signature and Illia of certiflar | | 29c. Lica | nsa number | | | 29d. Data sig | ned (Monti | h, Day, Yaar) |
| Tolward W. W. House | | 000 | 062 | | | August | 26, | 1997 |
| 30. Name and address of parson who completed causa of death (Nem 23a) (Type Edward W. Ditto, III, M.D. | | | | | | | | |

100 P3 DUA

| | Please Type or P State of | | | | | All Copies Mental H | | - | 27092 |
|-------------------------------|--|-------------------------------------|---------------------------------|--------------------------------------|--|--|----------------------------------|------------------------------|---|
| | | | Certif | ficate of | Death | | Reg. No. | , | 21072 |
| | 1. Decedent's Name (First, Middle, Last) | | | | | 2. Date of D | eath | | 3. Time of Death |
| an cal | Roxanne NMI Sister | | | | | August | Day 24 | Yeer 1997 | 21:30 |
| er | 4a. Facility Neme (If not institution, give street end numb | oer) | | | 4b. City, Town, o | r Location of Dee | | nty of Death | |
| | Washington County Hospital | | | 100 | Hagorete | N-110 | | Woohin | oton |
| | 5. Social Security Number 6. Sex 7. | Age (In yrs. lest | | Under 1 Year | Hagersto | s. 8. Dete of B | irth | Washing 9. Birth | plece (State or Foreign |
| | 218-50-2687 1□M 2ÅF | 44 | Yrs. | lonths Deys | Hours Mi | n. (Month, D Feb. 26 | | | ary land |
| | Usual Residence of Decedent | 1.0 00 - | | | | | | | |
| 4 | 10a. Stete 10b. County | 10c. City, To | own or Locati | on | | | | | 10d. Inside City Limits |
| octo | Maryland Washington | | Hager | stown | | | | | 1 ☐ Yes 2 🕅 No |
| Director | 10e. Street end Number | | 1 | 10f. Zip Code | | | 10g. Citizen o | of What Cou | intry? |
| - | 11226 Greenmount Avenue | | | - 21 | 740 | | | USA | |
| Funeral | 11. Marital Status 12. Was Decede Armed Force | ent Ever in U,S. | 13. Was | Decedent of I | Ilspanic Origin? | (Specify Yes or Norto Rican, etc.) | 0- 14. R | lace - Ameri leck, White, | |
| | 1 Never Married 2 Married 1 Yes 2 | | | Yes Z No | Specify: | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | Spec | 14/1- | nite |
| q p | 3 ☐ Widowed 4 ☐ Divorced Year or Date | | | | | | Sper | any. | |
| Completed by | 15. Decedent's Education (Specify only highest grade completed) | 18 | Ba. Decedent (Give kind | 's Usual Occup of work done | eation during most of w d) | orking | 16b. Kind of | Business/In | ndustry |
| m | Eiementery/Secondary (0-12) College (1-4 | or 5+) | | | | | 0.11 | | |
| ပိ | 12 2 17. Father's Neme (First, Middle, Last) | | F | roofread | | (Flora A 6: 4.4) | | Emp loye | ed |
| Be | | | | | 18. Moiners N | ame (First, Middle | e, Maiden Sum | ame) | |
| P | Ernest Keedy Young | | | | | ane MI | | - | |
| | 19a. Informant's Name/Relationship (Type, Print) | 1 | 9b. Mailing A | ddress (Street | end Number or i | Rurai Route Numi | ber, City or Tow | m, State, Zip | p Code) |
| | Mary Matthews/POA | | 1618 Dua | al Highwa | ay Hagers | town, Mary | | | |
| | 20e. Method of Disposition 1 □ Buriel 2 □XCremation 3 □ Removal from Sta | 00.000 | of Disposition tery, cremato | on (Name of any or other pia | ce) | Date | 20c. Locatio | n - City or To | own, State |
| | 4 ☐ Donation 5 ☐ Other (Specify) | | sbura Ci | rematory | | 8-26-97 | Smiths | burg. N | Mary land |
| | 21. Signeture of Funeral Service Licensee | | 22. Na | ame and Addre | | | | 101 - 111 | |
| | 1 mis II / Cala | | USI | orne rui | neral Home | 425 S. C | ionocoche sport, Ma | | |
| | 23a. Part. Enter the divise, or complications that cau shock, or heart fairre. List only one cause on each immediate Cause (Final disease or condition resulting in death) | | | | auch as cardi | ac or respiratory | arrest, | | Approximate Interval Between Onset and Death |
| Jer | | Due to (or as | a consequen | ca of): | arun | and | | | |
| Examiner | b | Due to (or as | | | | | | i | |
| Exa | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying | Due to (or as | a consequen | ce or): | | | | 1 | |
| ca | Cause (Diseese or Injury that Initiated events | Due to forms | | | | | | | |
| \$ | resulting in death) Lest | Due to (or as | e consequenc | ca or): | | | | | |
| ₹ | d | | | | | | | | |
| Completed by Physician/Medica | Pert II. Other significant conditions contributing to death | n but not resulting |) in the under | tylng ca <i>u</i> se giv | en In Part I. | | tobacco use o | | o the cause of death? bably 4)(Unknown |
| leted b | | | | | | | an autopsy ormed? | ev | ere autopsy findings vailable prior to empletion of cause |
| THO I | | | | | | | Van a.W. | | déath? |
| ٥ | 25. Was case referred to medical | | | | no P: | | Yes 2 No | 1[| ☐ Yes 2☐ No |
| lo Be | examiner? | wines a Classic | Out-off to 1 | Oth | or. | eth (Check only | | | |
| Hon: | 27. Manner of Deeth 28a. Date of I | | . Time of Injury | 28c. Injur Wor | 4 LI Nursing | Home 5 Res 28d. Describe | how injury occ | | (y) |
| entitica | 3 Sulcide 6 Could not be determined 28e. Piaca of | Injury - At home, etc. (Specify) | farm, street, | | | 28f. Location City or To | (Street and Nur wn, State) | nber or Rura | al Route Number, |
| Medical Certification: | 29a. Certifier (Check only one) 12 Certifying Physician: To the be 2 Madical Examiner: On the basis and manner | of exemination a | ge, death occ and/or Investi | curred et the tir gation, in my o | ne, date and pleo pinlon, death occ | e, and due to the curred at the time, | cause(s) end i date and place | manner as s a, and due to | stated. the cause(s) |
| Σ | 29b. Signeture end title of certiller | | | 29c. Licens | e number | | 29d. Date sign | ned (Month, | Day, Year) |
| |) / Wy | hus | | 195 | 3853 | | 8 | 1201 | 27 |

State Registrar

Physiciar /Medica Examine

_cFuneral Director

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mertal Hygiene. Important: If Item 27 is merked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical **Examiner**

To the Hospital or Attending Physician: The law requires that the death certificete be executed within 24 hours effer deeth.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit

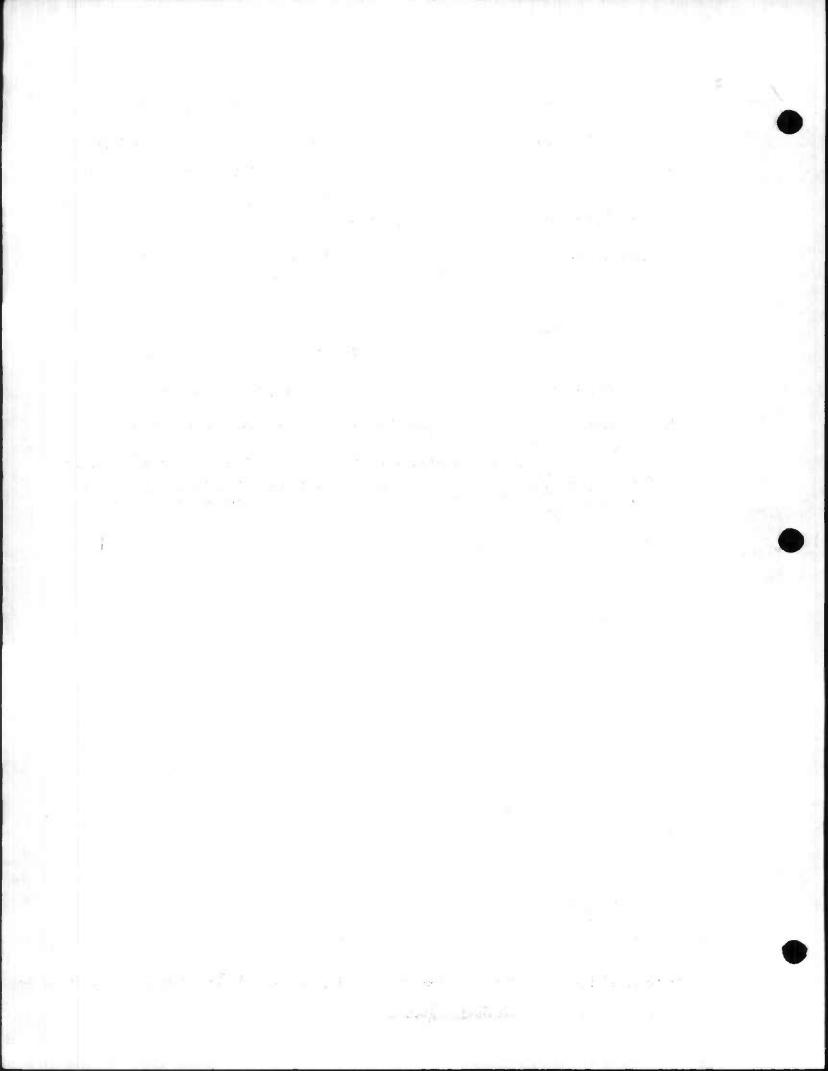
Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

AUG 26 1997

mo 11100 Medical Campus Rd 430 Hagerstaun, mo 21742
32. Registrer's Signeture Frederic H. Kass III mo
31. Dete filed (Month, Day, Year)
32. Reg Jula Davidson Randece

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death Physician Phyllis Victoria Sword 4b. City, Town, or Location of Death 23 /Medical 4c. County of Death 4a. Facility Nama (If not institution, give street and number) Examiner Washington County Hospital Hagerstown, Washington If Under 1 Yaar | If Under 24 Hrs. | 8. Data of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1 M 2 F 214-34-0994 60 Yrs. Director Oct. 14, 1936 Usual Rasidance of Decedant the Marylend 10a Stata 10b County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examples, must be notified at Director YSYas 2□ No Washington MD Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 53 East North Ave. 21740 U.S.A. 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yas, Giva Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1□ Yas 2√No Specify: py Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Business/Industry 12 should be filed within hand Mental Hygiene.
7 Is marked other than "r Elamantary/Secondary (0-12) College (1-4or 5+) Homemaker residence 10th grade 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Albert Hart Catherine I. Wilev 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Pages 1 and 2: Department of Health at Important: If Item 27 is any Injury or other trau Edwin Sword 53 East North Ave. Hagerstown, MD 21740 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Ce. August 27, 1997 Hagerstown, MD 21. Signature of Funarai Sarvice Licensaa 22. Nama and Addrass of Facility Thompson Funeral Home, Inc. nsa, or complications that causad the death. Do not antar the mode of dying, such as cerdiac or respirately arest, MD 2.1.722 Approximate to the control of Intarval Batween Onset and Death **Physician** /Medical Immediata Causa (Final a POSSIBLE COMONARY ARTERY DISEASE
Dua to (or as a consequence of): diseasa or condition rasulting in death) **Examiner** Physician/Medical Examiner MORBID OBESITY

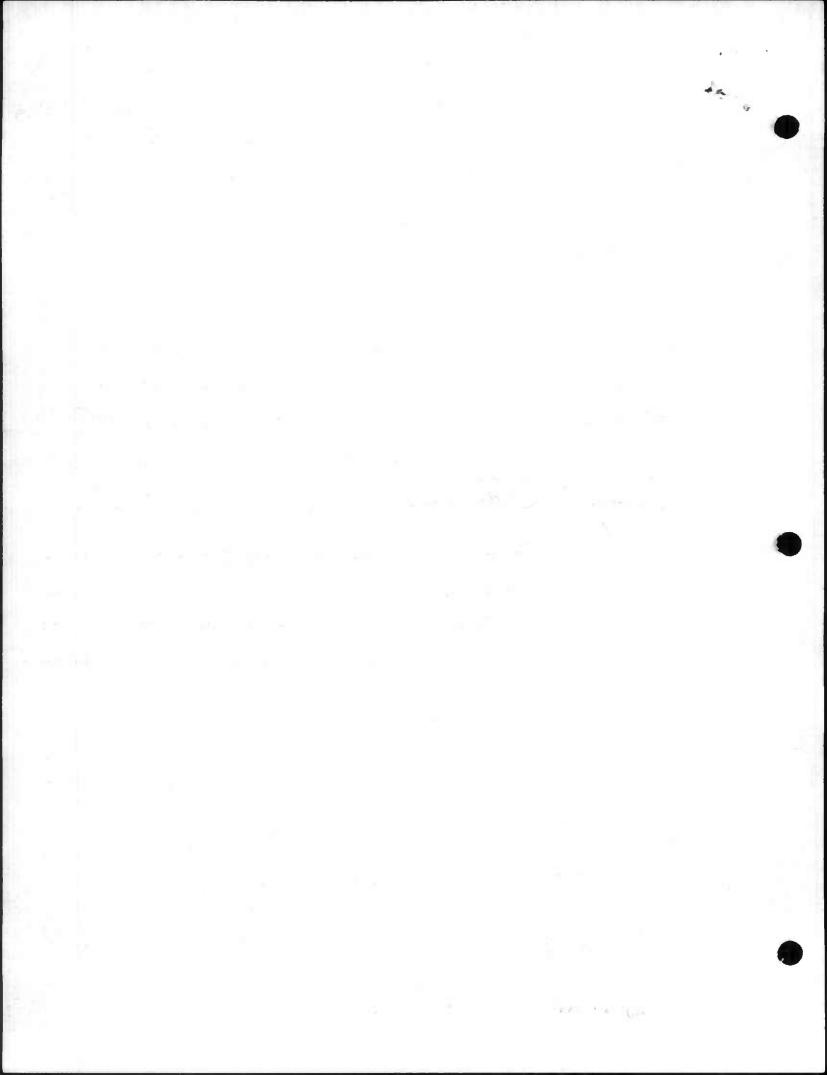
Dua to (or as a consequence of): 54RRS Sequentially list conditions, if any, laading to immadiata ceusa. Entar Underlying Causa (Disaasa or Injury that Initiated avants rasulting in death) Last RESPIRATORY HYPOVETILATIONSYNDROME.

Dua to (or as a consequence of): POSSIBLE PULMONARY EMBOLISM Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown me P Be Completed 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to complation of cause of death? 1 Yas 2 No 25. Was cesa raferrad to medicel axaminar? 26. Placa of Death (Check only ona) Othar: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Data of Injury (Month, Day Yaar) 27. Mannar of Death 28b. Tima of 28d. Dascribe how Injury occurred NIA 5 Panding Invastigation 1 Natural PA 2 Accident 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) NA 6 Could not be datamined 3 Sulcida 28f. Location (Straat and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct completaly filled in by 4 Homicida NA 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar Medical 29b. Signature and titla of certifier 29c. Licanse number 29d. Date signed (Month, Day, Year) Manzen genaj D28365

State Registrar

J. SHAFI 36 8 MILL 32 Registrario Signatura STREET HAGERSTOW MD 21740

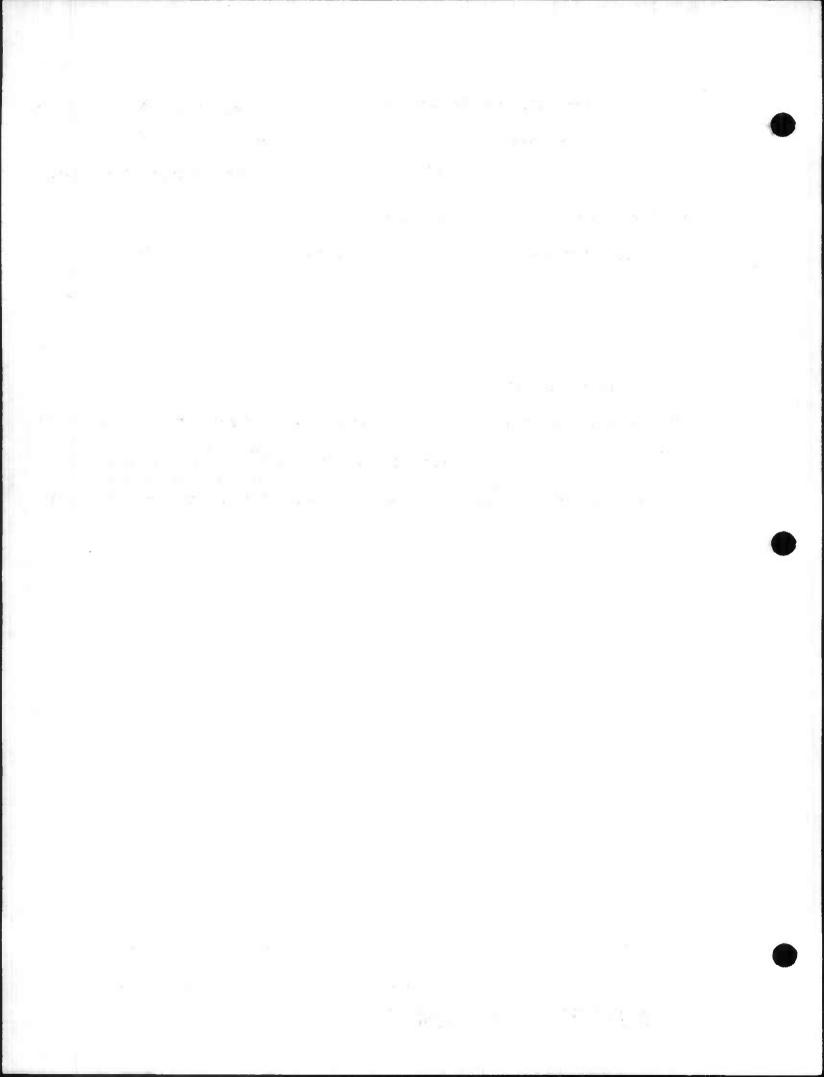
30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q 7 2 7 0 0 legions of the Print Index Inde

| | | | | | - | Certificate of | | | Reg. No. | 4 | 1094 |
|--------------------------------|--|----------------|--|---|--------------------|---|---|--|--|--------------------------------|---|
| | Physic | ian | Decedent's Neme (First, Middle, La Norman | | ST. JEAN | I. SR. | | 2. Data of De Month | Dev | Yaar | 3. Tima of Death 450 Cm |
| | /Medi Examir | | 4a. Facility Nema (If not Institution, give | | , c obin | , 52 | 4b. City, Town, or | August Location of Death | 23, 199 | | 9- PM |
| | EXCITII | ier | 11016 Lakeview l | | | | Hagerst | | Wash | | n |
| | Funeral Director | | 039-24-5113 | Sex 7. Age | (In yrs. last birt | hday) If Under 1 Yea Months Deyr | | | th y. Year) 1,1938 | g. Birthple Countr Rhode | ace (State or Foreign (Y) Island |
| | puel w | | Usual Rasidence of Dacedant 10a. Stete 10b. County | | 10c. City, Town | or Location | | | | 10 | d. tnside City Limits |
| | Mary | tor | Maryland Washing | ton | Hagers | stown | | | | | 1 ☐ Yas 2 ☐No |
| | or 284 | Director | 10e. Street and Number | | | 10f. Zip Coda | | | 10g. Citizen of W | | γ? |
| | ath w | | 11016 Lakeview D | rive | | | 740 | | U.S. | Α. | |
| Baltimore, Maryland 21215-0020 | permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Nerma 23a or 28a-f show any Injury or other traumatic event, the Medical Exercises must be notified at once. | by Funeral | 11. Meritel Stetus 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced | 12. Was Decedant E Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Yeer or Datas: | | 13. Was Decedant of If Yes, specify Cu 1 ☐ Yas 2 ☑ No | | pecify Yes or No to Rican, atc.) | 14. Race Bleck Specify: | - Amarica , Whita, at wh | |
| 5-0 | 72 ho | eted | 15. Decedant's E (Specify only highest gre | ducation | 16a. | Decedant's Usual Occu (Give kind of work don | upation | rkina | 16b. Kind of Bus | siness/Indu | ıstry |
| 121 | vithin han | Completed | Elamantary/Secondary (0-12) | Collaga (1-4or 5- | | life. DO NOT usa ratir supervison | ed) | Au g | ribbo | n mfo | |
| d 2 | Hygie ther t | ပိ | 0-12 17. Fethar's Nama (First, Middle, Last |) | | supervison | | ma (First, Middle, | Maiden Sumeme | | , • |
| lan | lid be fental ked o | To Be | Louis A | . St. Jean | ı | | 1 | | Gaffney | | |
| lan | 2 short | | 19a. Informant's Neme/Ralationship (| | | Melling Addrass (Strae | | | | | , |
| e, Z | feeith m 27 her tr | | Mrs. Patricia St | . Jean | |)16 Lakevie Disposition (Nama of | w Drive, | | | | |
| nor | or of h | | 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ | | cemater | y, crematory or other pl | | ug27 | 20c. Location - C | | |
| Ħ | nit. P artme ortam Injun | | 4 ☐ Donation 5 ☐ Other (Specification of Funeral Service Licer | | Cedar | Lawn Memor | | | Hagerstor Funeral | | aryland |
| ä | Depariment Department on the partment of the p | | 1 SCATT | m 8hs | MUL | 415 East | | | | | vland |
| | Physician /Medical Examiner | | 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Finel disease or condition resulting in death) | a. Me | he deeth. Do n | consaquance of): | ring, such as cardiad | c or raspiratory a | rest, | | Approximata Intarval Between Onset end Deeth |
| | pet usit | Examiner | | b | | 1 | | | | 1 | |
| Ć | execu in end rial-tra | Exai | Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying | | oua to (or as a c | onsequence of): | | | | | |
| 68760, | ficete be executed physician end as the bural-transit | edical | Causa (Disease or Injury that initieted events rasulting in death) Last | c | ua to (or as a c | onsequence of): | | | | | |
| | 75 D 61 | | | d | | | | | | | |
| Box | eath certif ettending I for use a | clan | | | | | | | | | |
| P. 0. | es thet the death cer igned by the ettendin be detached for use | Physician/M | Part II. Other significant conditions of | ontributing to death but | not rasulting In | the undarlying causa g | iven in Part I. | | | | the cause of death? ably 4 Unknown |
| ecords, | ew requires by been size should | Completed by | | | | | | 24e. Was | an autopsy med? | aval | re autopsy findings labla prior to upletion of cause eath? |
| <u> </u> | | Con | | | | | | 10 | Yas 2 10 | 10 | Yas 2□ No |
| <u> </u> | ystcian: The is s certificate he director, page | Be | 25. Was casa referred to medical axaminar? | Hospitel: | | | ther | ath (Chack only o | | | |
| ō | | To To | 1 ☐ Yas 2 ☐ No 27. Mannar of Death | 26e. Deta of trijun | 28b. T | patient 3LI DOA | 4 Li Nursing r | | dence 8 Other | | |
| Division of Vital Record | To the Hospital or Attanding Physician: within 24 hours effer death. To the Funeral Director: After this certification properties of the funeral director. | Certification: | 1 Natural 5 Panding 2 Accident Invastigation 3 Sulcide 6 Could not b determined | 00 - 01 11-1 | y - At home, fer | |]Yas 2□No | 28f. Location (: City or Tox | Street and Numbe vn, State) | r or Rural | Route Number, |
| | To the Hospital of within 24 hours eventually to the Funeral Decompletely filled | edical C | 29a. Certifier (Check only one) | ysician: To the best of ntner: On the basis of a and manner state | examination and | deeth occurred at the for invastigation, in my | time, dete end place opinion, death occu | , and dua to the irred et the time, | cause(s) end man dete and pleca, er | nar as sta nd dua to t | ted. tha causa(s) |
| | vithir To th comp | Me | 29b. Signatura and titla of certifier | | | | nsa number | | 29d. Data signed | | |
| | | | 30. Nama and address of person who Michael J. M. 31. Data filed (Month. Day, Year) | 1. Mulu | mel | MO. P | 14166 | | 8.2 | 5.9 | 7 |
| | | | 30. Nama and address of person who | completed causa of de | ath (Item 23e) (| Type, Print) | ~ | | 2 12 | 100 | d |
| | Sta | te | | 32. Registrar | 's Signatura | 1110 Mad | ICAL CAN | your Su | 1100 | VE5 e1 | 3 (OUA, INI) |
| | | | AUC 2 5 1007 | 16 8 | 50 | 10.100 | | | | | |

AUG 2 5 1997



State of Maryland / Department of Health and Mental Hygiene 0.7 2.7.0.0.5

| _ | | | | | | | tificate c | of Death | | Reg. No. | 1 6 | 27093 |
|--|--|------------------|---|---|------------------------------|------------------------|-------------------------------------|--|--|---|-------------------------|--|
| | Physic | an | Decedent's Name (First, Middle | | | | | | 2. Date of D Month | | Yeer | 3. Time of Death |
| Į. | /Medi | | Mary DeMarr | Sticke | | | | | Augus | | 997 | 7:52p.m. |
| 40 | Examir | ner | 4a. Facility Name (If not institution | | | a a a | 4150 | | or Location of Dee | | | |
| | | | Stickle Farm 5. Social Security Number | | apin R le (In yrs. last b | | If Under 1 Ye | Nanjem ar if Under 24 F | | | rles | |
| 0 | Funeral Director | | 577-24-1922 Usual Residence of Decedent | 1□M ¾(X F | | Yrs. | Months Day | | lin. (Month, D | ey, Year) BER 7,19 | 320 | place (Stele or Foreign intry) AQUASCO, MI |
| flend | Mo M | | 10a. State 10b. County | | 10c. City, To | wn or Loc | eation | | | | | 10d. Inside City Limits |
| Man | 6 2 | ctor | MD. CHARL | .ES | NANJ | EMOY | | | | | | 1 Yas 2 No |
| h with th | 23a or 28 | Funeral Director | 10e. Street and Number 4150 CHINQUAPIN | ROAD | | | 10f. Zip Code 20662 | | | 10g. Citizen of USA | What Cou | untry? |
| d 21215-0020 filed within 72 hours efter deeth with the Maryland | Department of result end Mentel Pryslete. Department of result end where the present a continue of them 23a or 28a-f show any injury or other traumatic event, the Medical Examinet must be notified at ODGs. | by | 11. Marital Stetus 1 Never Married 2 Marrie 3 Married 4 Divorced | 12. Was Decedent Armed Forces? ed 1 Yes 2 If Yes, Give Yeer or Detes: | | | Ves Decedent of Yes, specify C | of Hispenic Origin? uban, Mexican, Pu No <i>Specify:</i> | (Specify Yes or Nerto Rican, etc.) | o- 14. Ra Bla Specii | ck, White, | ican Indien, , atc. ITE |
| 5-0 72 h | natur Great | Completed | 15. Decedent (Specify only highes | 's Education t grade completed) | 166 | a. Decede | ent's Usuel Oc | cupation ne during most of a lired) | workina | 16b. Kind of 8 | usiness/îr | ndustry |
| 121 if | han a | mple | Elementary/Secondery (0-12) | College (1-4or | 5+) | life. D | | | | | | |
| CO P | the the | CO | 11 17. Father's Name (First, Middle, L | l acti | | | POST | MASTER 18 Methodol | leme (First, Middle | | | L_SERVICE_ |
| ylan ould be | 0 P 0 | Be c | | | | | | 100000000000000000000000000000000000000 | | | ne) | |
| Maryland | end Me | P | THOMAS 0. 19a. Informant's Name/Reletionsh | | 19 | h Mailin | Address (Str | eet and Number or | LIAN A. | | State 7i | in Code) |
| | n 27 ie | | | STICKEL SR. | | 4035 | CHINQU | JAPIN RD. | | | | |
| 0 87 | nt: If iten | | 20a. Method of Disposition 1 ☑ Buriat 2 ☐ Cremation 4 ☐ Donetion 5 ☐ Other (Sp. | | cemet | ery, crem | ition (Neme of atory or other p | cemetery | 8-28-97 | 20c. Location | | |
| Baltimo | y inju | | 21. Signature of Funeral Service i. | | Onki | 22. | Neme end Ade | dress of Facility | | | 71,5 11 | |
| m § 8 | any ir | ma | -y SHANNON RAMI | DET MOOTOO | | | | T FUNERAL | | | 156 | |
| - | - 7 | | 23e. Pert1. Enter the diseese, or a shock, or heart failure. List of | complications that caused | the deeth. Do | not ente | r the mode of c | WASHINGT tylng, such es card | In CN RD P | arrest, | T20 | Approximata |
| Phy | ysician | | SHOOK, OF HEER TAILUIE. CISC | one cause on each in | ie. | | | | | | | Interval Between Onset and Deeth |
| | ledical aminer | | Immediate Ceuse (Final disease or condition | Lung | Cance | er | | | | | | 142. |
| EX | ammer | | resulting in deeth) | a | Due to (or es e | | uence of): | | | | | |
| 8 | isit | ine | | b | | | | | | | 1 | |
| 68760, tificete be executed | physician end ss the burial-transit | Examiner | Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury | | Due to (or es e | consequ | ience of): | | | | | |
| 68760, ficete be ev | sicla e bur | cal | thet initieted events | c | Due to (or as a | COREAGU | ence off: | | | | | |
| 68 Tifficet | | Aedical | resulting in deeth) Last | | 000 10 (01 23 2 | consequ | ence on. | | | | | |
| P.O. Box | igned by the attendin be detached for use | an.A | ` | d | | | | | | | | |
| dea dea | of be | Physician/ | Pert II. Other eignificant condition | ns contributing to death b | ut not resulting | in the un | derlying cause | given in Part I. | 23b. Dld | tobacco uee co | ntribute t | to the cause of death? |
| G # | d by t | Phy | | | | | | | 1 | Yee 2 No | 3 Pro | bably 4 Unknown |
| S, as | bed bed | by | | | | | | | | | T | |
| I Records, P.O. Box The lew requires that the death cer | been si should I | Completed | | | | | | | | s an autopsy ormed? | 8/ | Vere autopsy findings vallable prior to ompletion of cause |
| 3ec | hes t | mpi | | | | | | | | | of | f death? |
| <u>a</u> = | nis certificate hes b I director, page 2 s | | | | | | | | 1 🗆 | Yes 2 No | 1 | ☐ Yes 2☐ No |
| of Vita Physician: | recto | Be c | 25. Wes case referred to medical examiner? | Hospitel: | | | | Othor | Death (Check only | | | |
| o E | r this | ٦. | 1 Yes 2 No | 28a. Dete of Inju | | Time of | 3LI DON | 4 CHANISHI | Home — FRes | how injury occu | | ify) |
| Division of Vital Records, or Attending Physician: The lew requires the physician: | Mrector: After this in by the funeral | Certification: | 1- Natural 5 Pending | (Month, Da | y Year) | Injury | | njury et Vork? ☐ Yes 2 ☐ No | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | |
| VISI After | Director: | iffice | 3 Suicide 6 Could not determine | ned 286. Piece of Inju | | arm, stre | et, fectory, offic | 00 | 28f. Location | (Street and Num. | ber or Rur | ral Route Number, |
| | ni Di | Cert | THE TRANSPORT | building, etc | с. (эреспу) | | | | City or re | wii, Siele/ | | |
| DIVISIO To the Hospital or Attendit within 24 hours after death | To the Funeral Completely filled | edicai | 29a. Certifier (Check only one) Certifying 2 Medical E | Physician: To the best of xaminer: On the basts of and menner ste | examinetion e | e, death nd/or inve | occurred et the estigation, in m | time, dete end ple y oplnion, deeth oo | ece, end due to the courred at the time | cause(s) end m , date and plece, | enner as : and due l | stated. Io the cause(s) |
| To th | Toth | Me | 29b. Signature and title of certifier | | | | 29c. Lice | ense number | | 29d. Dete signe | d (Month, | , Day, Year) |
| | | | Koull | M. M | all | | D2 | 8352 | | Augus | t 27 | 1, 1997 |
| | | | 30. Name and address of person w Krishan | Mathur, M | | | | x 2729, | La Pla | ta, MD | 20 | 0646 |
| | Sta | te | 31. Date filed (Month, Dey, Year) | | er's Signature | _ | | | | | | |
| 1 | Registr | ar | AUG 2 81 | 1997 Adii | Musles | Rarda | Ц | | | | | |
| - | | | | 1/ | | | | | | | | |

DHMH 16 Rev 6/95

The Section 2 and the section of " all the second to be a first that the second the

State of Maryland / Department of Health and Mental Hygiene 97

| | | | | | Ce | ertificate (| of D | eath | | R | eg. No. | | | |
|--|----------------|--|--|--|----------------------------------|--|-------------------|------------------------------------|-------------------------|---|----------------------------------|-------------------------|---|-----------------|
| Dhuoi | olon | Decedent's Name (First, Middle, La | • | | | | | | | 2. Date of Dear | th Day | Year | 3. Time | of Courth |
| Physi- /Med | | Thelma V | '• S | terli | ng | | | | | August | | | 9:42 | p.m. |
| Exam | | 4a. Facility Nama (If not Institution, given Edw. W. McCready | | | pital | | | Crisf | | cafion of Death | 4c. County Some | of Death erset | | |
| Funera Directo | | 217-05-8106 | Sex 1 M 2 F | 7. Age (In yi 80 | rs. last birthda Yrs. | y) If Undar 1 Y Months Do | ear | If Under: Hours | 24 Hrs. Min. | 8. Date of Birth (Month, Day) Feb. 4, | Year) | 9. Birth Cou Mai | placa (State intry) Cyland | or Foreign |
| Meryland a-f show | ctor | Usual Rasidanca of Decadent 10a. Stata 10b. County Maryland Somers | et | 10c. | City, Town or | Location isfield | | | | | | | 10d. Inaide | City Limits |
| or 28 | Director | 10e. Streat end Number | | | | 10f. Zip Co | | | | 1 | Og. Citizan of \ | What Cou | ntry? | |
| 23a | iai | 281 Somers C | ove Apt | s. | | 2 | 181 | 17 | | | USA | | | |
| Fe, Maryland 21215-0020 I and 2 should be filed within 72 hours after death with the Meryland Health and Mentel Hygiene. The marked other than "natural", or flems 23s or 28s-4 show other traumatic avant, the Medical Examiner must be notified at | by Funeral | 11. Merifel Stefus 1 Nevar Married 2 Married 3 Widowed 4 Divorcad | 12. Wes Dec Armed Fo 1 Tas If Yes, Gir Yaar or D | orces? 2 X No va | U,S. 13 | Was Decedent If Yas, specify (| | panic Ori , Maxican Specify: | gin? (Spe , Puarto I | cify Yas or No- Rican, etc.) | | ck, Whita, | can Indian, atc. | |
| 2-0 | e d | 15. Dacadant's E | ducation | | 18a. Dec | edant's Usual O | ccupat | ion | and commentation | | 16b. Kind of B | usinass/ir | ndustry | |
| 21215-0020 de within 72 hours af giene. pr then "natural", or then "natural", or the Medical Exam. | Completed | (Specify only highast gr. Elementery/Secondary (0-12) Grade 8 | College (| 1-4or 5+) | | ra kind of work de DO NOT usa ra Cretary | ntired) | iring mosi | OI WORK | ng . | Hospit | tal | | |
| Maryland 2121 d 2 should be filed within th and Mental Hygiene. 7 Is marked other than ' | To Be (| 17. Fathar's Nama (First, Middle, Last William Roa | , | | | | 1 | | | (First, Middle, I | | na) | | |
| 2 sho and I | 1. | 19e. Informant'a Neme/Ralationship | (Type, Print) | | | iling Address (St | | | | | | State, Zi | p Code) | |
| Baltimore, M permit. Peges 1 and 2 Department of Health. Important: if item 271 any Injury or other tra | | George D. Evans, | Sr. (s | | | O. Box | | 28 - | Selb | 4 | | 19975 | | |
| Saltimore, emit. Peges 1 ar Pepartment of Hea mportant: if item; | | 20a. Mathod of Disposition 120 Burial 2 Cramation 3 D | Removel from | State | cematary, cr | position (Nama o ematory or other | placa, | | | | 20c. Location - | | | |
| Baltimory permit Peges Department of H Important: If Ne | | 4 □ Donation 5 □ Other (Special | | Su | | ge Memor | | | | 23/97 | Crisf | ield, | MD | |
| Demii Pepar Impor Impor | | 21. Signature of Funeral Service Lice | | Com | | 22. Nema and Ad Bradsh | | | | uneral | Home | | | |
| _ 40240 | | Robert H. Bra | dshaw | | | 306 W. | Ma | ain S | 5t | · Crisfi | eld, MI | 21 | 1817 | |
| | | 23a. Part1. Enter tha disaasa, or com shock, or haart failure. List only | plications that of one cause on a | aused tha de ach lina. | ath. Do not a | nfar fha moda of | dylng, | such as | cardiac o | r raspiretory err | ast, | | Approxim Interval B Onset en | atween |
| Physician /Medical Examine | | Immediata Cause (Final disaasa or condition rasulting in daath) | a | Acut | EN | 140 CA | RD | IAL | | INFAK | CTION | | 81 | 7 |
| 4.015 | ē | The state of the s | | | (or as a cons | | | | n | 2015 | | 1 | 9: | yean. |
| uted | Examiner | Constitution of the consti | b. ——— | - | ONALY | | LR | -7 | NIJ | EAJE | | i | • | 0 |
| owec an an rial-tr | | Sequantially list conditions, if eny, leeding to immadiate cause. Enter Undarlying Causa (Diseasa or Injury | | 11 | 1.0 | FNJ (0 | . 1 | | | | | 1 | 20 | 98 |
| X DS/DU, ertificate be executed fing physician and ees the burial-transit | Medical | Causa (Diseasa or Injury that initiated evants rasulting in daath) Last | C | Dua to | (or as a conse | | .0 | | - | | | | | - |
| .U. BOX 68/6U, the death certificate be executed If the attending physician and to the of or use as the burial-transit | | L | d | | | _ | | | | | | 1 | | |
| the day | Physician | Part II. Other significant conditions of | confributing to de | eath but not r | asulting in tha | underlying cause | a givar | n In Part I. | | 23b. Did to | obacco use co | ntribute 1 | to the cause | of death? |
| म क री क | | Non INSULIA | S DEP | ENDE | NT P | IABETI. | ٔ ر | PIELI | Tus | 1 🗆 Y | es 2 No | 3 🗆 Pro | obably 4[| Unknow |
| ord requir een s hould | Completed by | CERCISKO V | | | | | | | | 24a. Was a perform | n autopsy med? | a | /are autopsy vallable prio ompletion of | rto |
| The law ate has b | m d | | | | | 3-21 | | | | | | 1 | daath? | |
| = F and | ပိ | 25. Was casa rafarrad to madical | | | - | | | 20. 8 | | 1 Y | | 1 | ☐ Yes 2[| ∐ No |
| | 0 | examiner? | Hospitel: | npatiant 2 | ☐ ER/Outpati | ent 3 DOA | Other | | | (Check only or na 5□ Raside | | as /Casa | 6.1 | |
| 0 4 5 5 | Ξü | 27. Manner of Death | | of Injury th, Day Year) | | of 28c. | Injury 8 Work? | | | 28d. Describe h | | | 197 | |
| nding fath. | atio | 1 ☑Netural 5 ☐ Pending 2 ☐ Accidant invastigatio | | m, Day rear) | Injury | | | as 2 🗆 1 | No | | | | | |
| LIVISION al or Attending a after death. I Director: After d in by the fune | Certification: | 3 ☐ Suicida 6 ☐ Could not b 4 ☐ Homicida determinad | 28e. Plece buildi | of Injury - At ng, etc. (Spe | homa, farm, s | street, fectory, off | ice | | 4 | 28f. Location (Si City or Town | treet and Numb n, Stata) | per or Rui | al Route Nu | ım <i>ber</i> , |
| To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune | edicai (| 29a. Cartifiar 1 Certifying Pr (Check only one) 2 Medical Exam | niner: On tha ba | best of my k asis of axami nar statad. | nowledga, daa nation end/or l | ath occurred at the investigation, in r | a time | , data an nion, daei | d plece, e | end due to tha co | euse(s) end ma ata and placa, | anner es : and due ! | statad. to tha cause |)(S) |
| To the To the comp | × | 29b. Signature end fifla of cartifier | | | | 29c. Lic | ansa | number | | 2 | 9d. Dafa signe | d (Month, | Day, Year) | |
| | | Dosantha. 6 | | | | | ೮೨ | 517 | 36 | | 8 | 120 | 192 | |
| | | 30. Nema and address of person who Vasantha P. P | | | | | - | Cris | fiel | d, MD 2 | 1817 | | | |
| St Regis | ate trar | 31. Deta filed (Month, Day, Year) | 26 1997 | egistrar's Sig | matura . | -Randall | | | | | | | | |
| DHMH 16 Rev 6/ | 95 | MUUA | J U IOOP | 0 | | | | | | | | | | |

9 70 0 2001 2 190 A VII PRODUCE TO SERVICE TO SERVI

State of Maryland / Department of Health and Mental Hygiene

27097 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Day 1997 Month **Physician** August 3, Mary Elizabeth Tompkins 9:00 PM /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Nursing Center Leonardtown St. Mary's Hours Min. 8. Date of Birth (Month, Pay, Year)

June 19, 1917 If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthpiace (State or Foreign Country) **Funeral** Days Months 1 M 2 F 338-12-2382 80 Director Iowa Usual Residence of Decedent death with the Marylend 10a. Stata 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits 7 is merkad other than "natural", or items 23a or 28a-f ahov traumetic event, tre Medical Examinar mast be notified at Director 1 Yes 2 No Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21585 Peabody Street 20650 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian 11. Maritel Status Biack, White, etc. filed within 72 hours after 1 Never Married 2 Married ☐ Yes 2 No Yes, Give Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Widowed 4 ☐ Divorced White Year or Detes "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry pemit. Peges 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If itam 27 is marked other than any Injury or other traumetic event. The Mean Injury or other traumetic event. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Vincent R. Berkman Elvira Boyer 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Donald Tompkins, Son 26620 Forest Hall, Mechanicsville, Maryland 20659 20b. Plece of Disposition (Neme of 20a. Method of Disposition 20c. Location - City or Town, State Metropolitan Crenatory 1 ☐ Buriai 2 ■ Cremation 3 ☐ Removal from State 8/4/97 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) uneral Site 22. Name and Address of Facility Brinsfield Funeral Home, P.A.
22955 Hollywood Road, Leonardtown, MD 20650
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest,

Approximate Approximate Intervei Between Onset and Death **Physician** Immediete Cause (Finel disease or condition resulting in death) /Medical Cardiogenic Shock 12 Hours Examiner Due to (or as a consequence of): Examiner Acute Myocardial Infarction 24 Hours buriel-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or es a consequence of): Coronary Artery Disease ng physician a Box 68760, Physician/Medical Due to (or as a consequence of): esn signed by the atte Part II. Other aignificant conditions contributing to death but not rasuiting in the underlying cause given in Part i. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Recent Urinary Sepsis Records, by 24a. Was en eutopsy performed? Were autopsy findings eveileble prior to Completed Cerebrovascular Accident, Dementia peeu completion of cause of deeth? hes page 2 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificete 2 No Division of Vital or Attanding Physician: efter death. Director: After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funerel 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Neturei 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Placa of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours e Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) and menner es atated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete and pleca, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) within 2 29b. Signature ar 29d. Date signed (Month, Dey, Year) 29c. License number D01380 30. Neme and address of person who completed cause of death (Item 23e) (Type, Print) John F. Fenwick, M.D. 22650 Cedar Lane Court, Leonardtown, Maryland 20650 31. Dete filed (Month_Day, Year)

32. Registrar's Signature

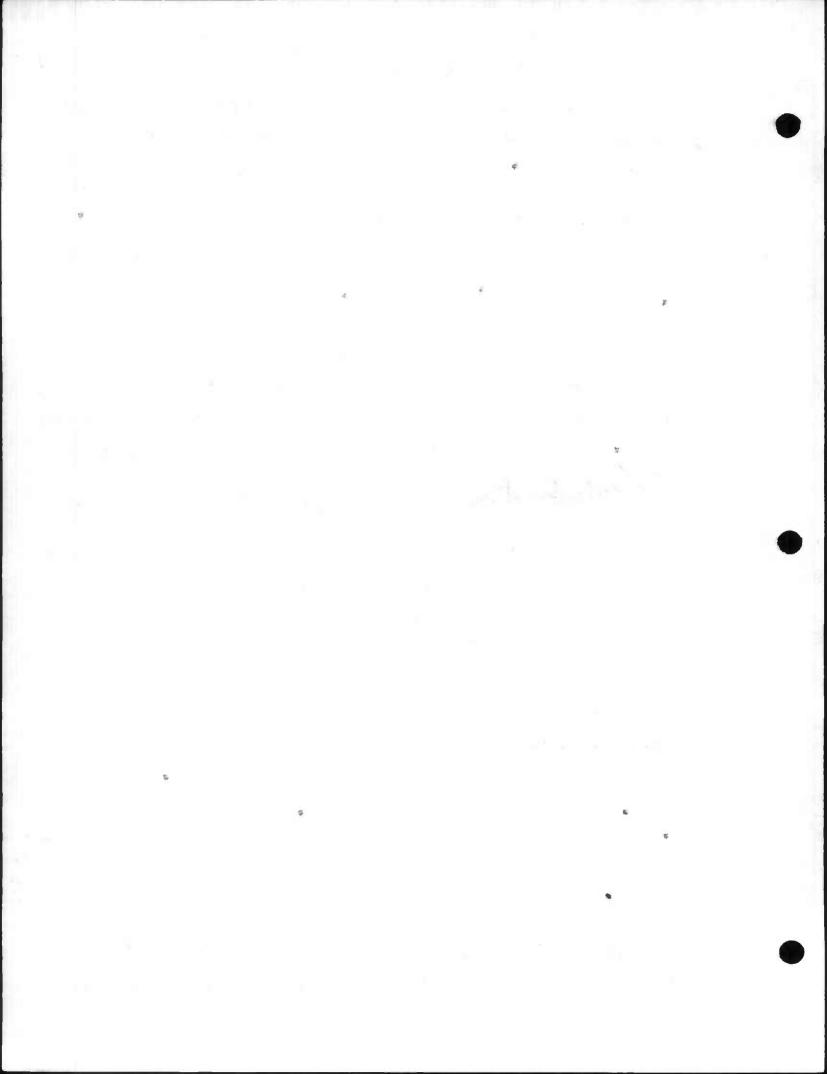
ali Davidson Rod. 11.

1997

DHMH 16 Rev 6/95

State

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

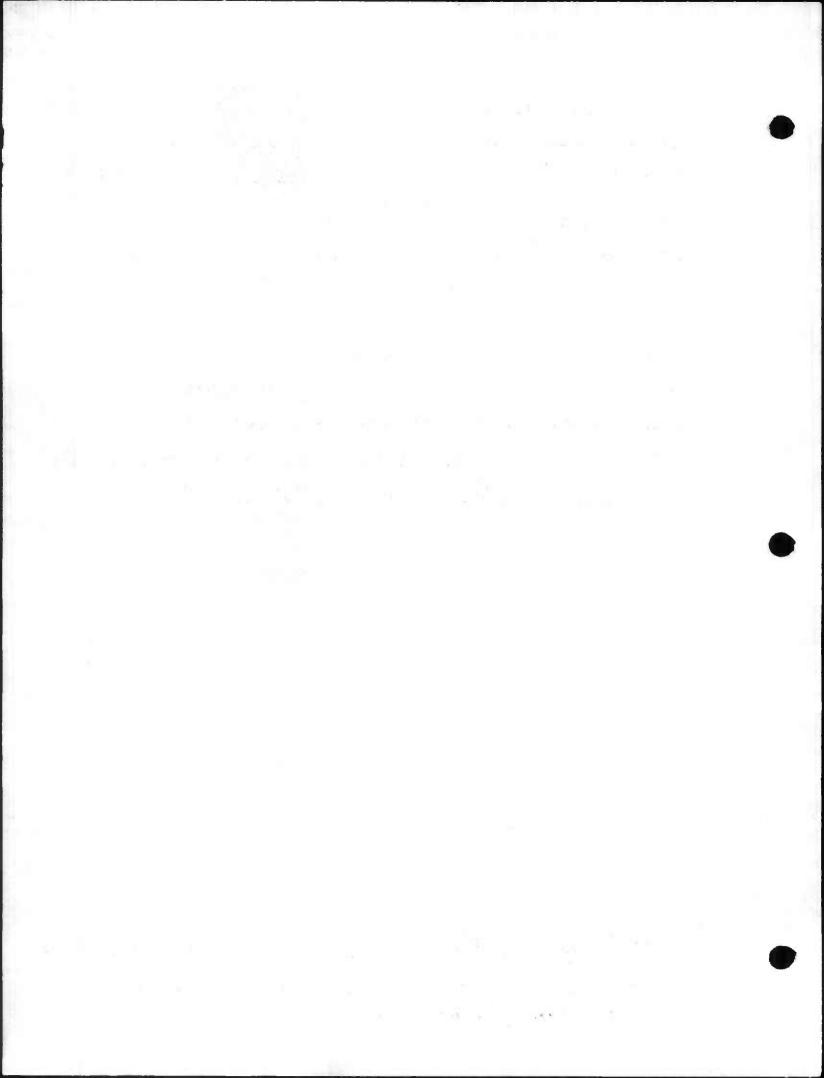
State of Maryland / Department of Health and Mental Hygiene 97 27008

| _ | | | | State of Mis | | epartment of recent of recent of the contract | | | Reg. No. | 1 4 | 1090 | |
|---------------------|---|--------------------|--|---|------------------------|---|--------------------------------|---|------------------------------------|--|---|--|
| п | Physic | ian | 1. Decedent's Neme (First, Middle, La Una B. | * | TTC | | | 2. Dete of De Month | ath Dey | Year | 3. Time of Deeth | |
| J | /Medi | | | TUL | PT2 | | | August | | | 11:15 PM | |
| 1 | Examir | ner | 4e. Fecility Nema (If not institution, giv Bayside C | enter | × | | 46. City, Town, or Lexingto | n Park | St. N | lary's | | |
| | Funeral Director | | 5. Social Security Number 6. S 289–24–6120 Usuel Residence of Decedent | | 77 Yrs | Months Dave | Hours Min. | B. Date of Bir (Month, De OCTOBE) | 23, 19 | 9. Birthpla Country 9 Kent | ce (State or Foreign | |
| | Maryland M show ified at | tor | 10a. State 10b. County Kentucky Jefferson | ı | 10c. City, Town o | | | | | | I. Inside City Limits | |
| | death with the Maryland the 23a or 28a-f show c.must.be.notified.at | ral Director | 10e. Streat end Number 8804 Perry Road | | | 10f. Zip Code 40222 |) | | 10g. Citizen of U.S.A. | What Country | n | |
| 020 | n 72 hours after death with the Maryles "natural", or Nems 23a or 28a-f show odjest Examiner must be notified at | by Funeral | 11. Maritel Status 1 Never Merried 2 Married 3 Widowed 4 Divorced | 12. Was Decedent E Armed Forces? 1 Yes 2 M If Yes, Give Yeer or Detes: | | 13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☒ No | | Specify Yes or No to Rican, etc.) | | a - American ck, White, etc v: iite | | |
| 3 | 72 h | etec | 15. Decedant's Ed (Specify only highest gre | ducation de completed) | 16e. De | ecedant's Usual Occup Give kind of work done fe. DO NOT use retire | petion during most of wo | nrkina | 16b. Kind of B | | stry | |
| 121 | filed within Hygiene. dher than " ent, the Mes | Completed | Eiamentary/Sacondary (0-12) | College (1-4or 5 | | fe. DO NOT use retire lousewife | d) | | Own Ho | ome. | | |
| d 2 | Hydie Hydie | | 17. Fethar's Neme (First, Middle, Last, | , | ** | 0450#110 | 18. Mother's Na | me (First, Middle, | | | | |
| lan. | should be nd Mental marked o marke eve | To Be | Brian Brewer | | | | Maud | Morrison | | , | | |
| Maryland 21215-0020 | nd 2 sho alth and N 27 is ma ir trauma | 15 | 19e. Informant's Neme/Reletionship (Terry J. Walker-E | Type, Print) Daughter | 2 ^{19b. M} | lailing Address (Streat 5 Caravel | and Number of R | ural Route Numb reat Mil | or City or Jown, | State Zin C 2063 | ode) | |
| Baltimore, | Pages 1 a nant of Ha int: If Nem iry or othe | | 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremation 3 ☐ 4X Donetlof 5 ☐ Other (Specif. | | cemetery. | isposition (Neme of cremetory or other pla on University | ca) George y Medical | August 8, | 20c. Location - Washingto | | n, Stete | |
| Balt | permit. Pag Department Important: any injury o | | 21. Signature Funerel Service Licer | Sep / | 7 | 22 Name and Addre Columbia Mor 225 Missouri | tuary Serv. Ave., NW, | ices, Inc. Washingto | n, DC 20 | 011 | | |
| | Physician /Medical Examiner | er | 23a. Plant. Enter the disease, or com- shock, or heert failure. List only Immediate Ceuse (Final diseasa or condition resulting in daath) | . Ce | celo | vascul | | * | | Ĉ. | pproximete ntarval Between haset end Deeth Weeks | |
| ox 68760, | certificete be executed and and buriel-transit use es the buriel-transit | n/Medical Examiner | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted evants resulting in deeth) Lest | c | Oue to (or es e con | | | | | | | |
| P.O. Box | het the death certi ed by the attending deteched for use | Physician/M | Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of the ca | | | | | | | | | |
| Vital Records, | ew requires to been signer 2 should be | Completed by | | | | | | | en eutopsy med? | availe | autopsy findings able prior to pietion of cause eth? | |
| Ä | 0 - 5 | E O | | | | | | 101 | res 2□No | 101 | res 2□ No | |
| /ita | ysician: The is certificate director, pag | Be (| 25. Wes case referred to medical exeminar? | | | | 28. Placa of De | eth (Check only o | na) | | | |
| ot | Physician: this certific ral director, | ို | 1 ☐ Yes 22 No | Hospital: 1 ☐ Inpatiar | nt 2□ER/Outpe | otient 3 DOA Oth | ner: 4 Nursing I | Home 5 Resid | denca 8 □Oth | er (Specify) | | |
| Division | Attending P or death. Sctor: After to the funerations of the funerations. | Certification: | 27. Manner of Deeth 1 Netural 5 Pending 2 Accidant investigation | | Year) 28b. Tim Inju | ry Wo | ry et * rk? Yes 2 □ No | 28d. Describe | now Injury occur | red | | |
| Divi | tal or Att rs efter d al Direct | Certific | 3 Suicide 6 Could not be datermined | 28e. Place of Inju building, etc | | , street, fectory, offica | | 28f. Location (S City or Tov | Street end Numb vn, Stete) | per or Plural F | Route Number, | |
| | To the Hospital or Attending F within 24 hours efter death. To the Funeral Director: After completely filled in by the funer | edicai | (Check only one) 2 Medical Exam | yeiclan: To the best of ninar: On the basis of and menner stel | exeminetion end/o | r Investigation, in my o | pinlon, deeth occi | a, end due to the urred et the time, | ceuse(s) end me dete and pieca, | ennar es stet end due to th | ed. ne cause(s) | |
|) | To the comple | 2 | 29b. Signature and title of certifier | m from |) | 29c. Licens D1 4 2 | | 1 | 29d. Dete signe August | | | |
| | | | 30. Nama end addrass of person who william D. Boyo | d, MD, 17 | Jeffer | rson Stre | eet, Leo | nardtown | n, MD 2 | 20650 | | |
| | Sta Registr | | 31. Data filed (Month, Day, Year) AUG 12 15 | 32. Registra | 's Signetura | dall | | | | | | |



State of Maryland / Department of Health and Mental Hygiene 0.7

| | | | | | | , | Cer | tificat | te of | Death | | Reg. No. | 1 6 | 10 | 99 |
|------------|--|----------------------|--|-----------------------------------|--|----------------------------|-----------------------------------|------------------------|-------------------|--|--|--------------------------------|--|-------------------------|----------------------|
| | Physic | an | 1. Decedant's Nama | (First, Middle, Las | st) | | | | | | 2. Data of D | eath Day | Yaar | | na of Death |
| | /Medi | | THOMAS WI | LLIAM TO | BAT, SR. | | | | | | Aug | 24 | 1997 | 2:: | 26 PM |
| | Exami | | 4e. Facility Name (If | | and the same | | | | | 4b. City, Town, o | r Location of Dea | th 4c. Cour | ty of Death | | |
| | | Н | DORCHESTE | | | L, | | | | CAMBRIDO | | DORC | HESTER | 1 | |
| | Funeral Director | | 5. Social Security Nu 220-01-729 | 95 | 9x TOM 2□F | ge (In yrs. 78 | last birthday) Yrs. | If Under Months | Deys | | | irth ay, Year) | 9. Birthp Coun MARY | lece (St to) LANI | tata or Foreign D |
| | pu s | | Usuel Rasidance of I | Decedent 10b. County | | 10c Cit | ty, Town or Loc | nation | | | | | | Orl. In al. | de City Limits |
| | show | 2 | 10000 | | 7.0 | | | | | | | | | | Yas 2 No |
| | the Mary | ect | MARYLAND I | | £K | E | EAST NE | 7 | | | | 10-04 | (110 - 1 0 | | 100 2010 |
| | 23e or | Funeral Director | 6140 SUIC | | GE ROAD | | | 10f. Zip | 216 | | | | SA | itry r | |
| 5-0020 | or he | þ | 11. Maritei Stetus 1 □ Never Marrie 3 → Widowed 4 | | 12. Was Dacedent Armed Forces' 1 ☑ Yas 2 ☐ If Yas, Giva Yaar or Detes: | 19 | 7.5 | Vas Dace Yes, spe | | | (Specify Yas or N arto Rican, atc.) | o- 14. R | ace - Amaric lack, Whita, hify: WH | | n, |
| 2-0 | 72 hours netural', | Completed | /Snorih | 15. Decedent's Ed | ucation | | 16a. Deced | ent's Usu | el Occup | pation | edina | 16b. Kind of | Business/Inc | dustry | 7 |
| 21 | C | ple | Elemantary/Second | y only highast gra derv (0-12) | College (1-4or | 5+) | lifa. C | OO NOT u | isa <i>retire</i> | during most of w | rorking | | | - | |
| 2121 | TO TO be and | No. | 10 | , (6 1.5) | | | WATE | RMAN | | | | SEAFO | OD | | |
| Maryiand | s 1 and 2 should be filed f Health and Mental Hygid tam 27 is marked other other traumatic event, II | Be (| 17. Fathar's Name (F | Irst, Middla, Last) | | | | | | 18. Mothar's N | ama (First, Middl | a, Ma <i>id</i> an Suma | ama) | | |
| yia | should be not marked or ma | 2 | FRANK JOSI | EPH TOBA | Γ | | | | | MAF | RY MADORI | KEY | | | |
| ar | 2 sho and is m | | 19a. Informant's Nen | ne/Ralationship (7 | ype, Print) | | 19b. Mailin | g Address | s (Street | end Number or i | Rurel Routa Num | ber, City or Tow | m, Steta, Zip | Coda) | |
| | of Health Itam 27 other tr | | DEBBIE A. | DONOVAN | /DAUGHTER | | | | | | ROAD, EAS | ST NEW I | MARKET | ',MD | 21631 |
| ore | f of H | | 20a. Mathod of Dispo | | Ramovai from Stata | 20b. F | Place of Dispos cematary, crem | sition (Name | ma of other pla | ce) | Data | 20c. Location | 7 - City or To | iwn, Stat | ta |
| Ē | | i | | Other (Specify | | OUR | LADY (| OF GO | OOD | COUNSEL | 8/28/97 | SECRE | TARY, | MARY | LAND |
| Baltimore, | permit. Pa Departmen Important any injury sacs. | | 21. Signature of Fup | eral Service Liche | 500 | e | ZE. | LLER | FUN | | ME, P. O | | 07 | | |
| | 1000 | 6 | 23a. Part. Enter the spock, or heart | disease, or comp | plications and cause | d tha daat | | | | | | | | Approx | lmata |
| 1 | Physician | | sb6ck, or heart | failure. (List only | one cause on each I | ina. | | | Í | | | | 1 | Intarval | Between and Death |
| | /Medical | | Immediata Cause (F | inal | Dan | | | | | | | | | 11. | , |
| | Examiner | | disease or condition resulting in death) | | . Droi | Whi | or es a consequ | | | | | | / | 7/40 | ntes |
| | | ē | | | | Due to (d | or es a consequ | uence of): | | | | | I | | |
| | icate be executed physician and s the burial-transit | Examiner | Convention to the | | b | Due to /c | or as a consequ | 10000 00 | | | - | | <u> </u> | | |
| Ć, | certificate be execut nding physiclan and usa as the burial-tran | Exa | Sequentially list condition, leading to immoduse. Enter Underhouse (Disease or Inthet Initieted events | nadiata | | D08 (0 (0 | n as a consequ | Jenice Oi). | • | | | | - | | |
| 68760, | e be but | cal | Cause (Disease or In thet initiated evants | jury | c | Due to (o | r as a consequ | iance of). | | | | | + | | _ |
| 68 | tificat ng phy as th | P | rasulting in death) La | st | | Dua to (o | as a consequ | iance oij. | | | | | | | |
| Box | ndin usa | 2 | | | d | | | | | | | | | | |
| | death | Icla | Part II. Other signific | ant conditions or | ntributing to death h | uit not ras | ulting in the un | dedvina c | causa ni | van in Part I | 23h Di | I tobacco use d | ontribute to | the car | uen of death? |
| P.O. | The law requires that the death cer ate has been signed by the attendir page 2 should be detached for usa | by Physician/Medical | 4 | | Direa. | | unting in the un | oanying c | Jausa y | vair air vairi. | | Yee 2 1 No | | | 4 Unknown |
| Records, | ulres sign | q p | | | | | | | | | 24a, Wa | s an autopsy | 24b. We | are auto | psy findings |
| Ö | v require been si should | Completed | | | | _ | | | | | per | ormed? | CO | allabla p | orior to of cause |
| Re | e law has ge 2 | E | | | | | | | | | | | | death? | |
| a | | | 05.144 | 4 | | | | | | | | Yas 2 No | 1L |] Yas | 2□ No |
| Vital | ystclan: The last certificate hadirector, page | Be | 25. Was casa referre axaminar? | | Hospitel: | . les | | | Oth | har | eath (Check only | | | | |
| o | Phys rthis ral di | - T | 1 ☐ Yes 2 ☑ N 27. Mannar of Deeth | 0 | 1 ☐ inpati | | ER/Outpetlent 28b. Time of | - | JA | ALI Nursing | Home 5 Res | how injury occ | | V) | |
| O | ding h. After | tion | 1 Natural | 5 Panding invastigation | 28a. Deta of Inju (Month, Da | y Year) | Injury | м | 28c. Inju Wo | rk?` IYas 2∐ No | 200. Dusonice | now injury occ | 31100 | | |
| Division | or Attending Physician: fter death. Mrector: After this certific in by the funeral director, | Certification: | 2 M Accident 3 ☐ Suicide 4 ☐ Homicide | 6 Could not be determined | 28e. Pleca of In building, a | jury - At he c. (Specif | oma, farm, stre | | | 7100 20110 | 28f. Location City or To | (Street and Nur own, Stete) | n <i>ber or Rur</i> a | Il Routa | Number, |
| | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral | edical Ce | (Check only 2 | ©XCertifying Phy ☐ Medical Exam | reician: To the best iner: On the basis o | faxamina | wiedge, death tion and/or inv | occurred astigation | et tha tio | ma, date end pleo ppinion, daeth oc | ce, end due to the | cause(s) end i | mannar as st | tated. | usa(s) |
| | the the mpie | Med | one) 29b. Signatura and tit | le of portifier | end mannar st | ated. | | 00 | a Lieer | se number | | 20d Data star | and /At-att | Day V- | orl |
| | 5 ± ₹ 5 00 | - | | | 20 1 | 11 | | | | | | 29d. Data sign | | | |
| | | | | my | am to | ne | ` | 1 | ソーコ | 1820 | 7 | Hugus | + 25 | ,19 | 177 |
| | | | 30. Nama and address | s of person who o | omplated causa of o | laath (itan | n 23a) (Type, F | Print) | | | | | | | |
| | | | Edmu | nd J | omplated causa of o | shli. | , 4 | Au | ros | a St. | Cambr | idge 1 | 40 2 | 161 | 3 |
| | Sta | _ | | Day, Year) | 32. Dist | ar's Signa | tura Randa | Ц | | | | | | | |



State of Maryland / Department of Health and Mental Hygiene 97 27 100

| | | | | | Ce | rtificate o | f Death | | | Reg. No. | | |
|---|------------------|---|----------------------------|---|------------------------|---------------------------------------|-----------------------|----------------|---|--------------------|----------------|--|
| Dhysisis | | 1. Decedent's Neme (First, Middle, La | st) | | | | | | 2. Dete of De Month | | Yeer | 3. Time of Death |
| Physicia /Medic | | THEOLA DUSENBERRY | TODD | | | | | | AUGUST | 20, 19 | 97 | 1549 |
| Examin | | 4e. Fecility Name (If not institution, give | e street and nu | m <i>ber)</i> | | | 4b. City, Tow | m, or Loc | cation of Deet | h 4c. Cour | nty of Death | |
| | L. | DORCHESTER GENERA | L HOSP | ITAL | | | CAMBRI | | | | HESTE | R |
| _c Funeral | | Social Security Number 6, S | ex □M 2DXF | 7. Age (In yrs. I | | If Under 1 Yea Months Day | | 4 Hrs. Min. | 8. Dete of Bir (Month, Da JAN . 5 | th | 9. Birth | place (State or Foreignty) |
| Director | | 249-36-9602 | LIM ZLAF | 71 | Yrs. | , | | | JAN. 5 | ,1926 | SOUTH | "CAROLINA |
| g * | | Usuel Residence of Decedent 10a. Stete 10b. County | | 10c. City | y, Town or Lo | ocation | | | | | | 10d. Inside City Limit |
| ith the Marylan or 28a-f show e notified at | 5 | MARYLAND DORCHEST | ED | | | MARKET | | | | | | 1 ☐ Yes 2 🛱 N |
| the M 28a-f notifie | ect | 10e. Street and Number | EK | LAS | T MEM | 10f. Zip Code | | | T | 10a Citizan a | 6 Milhau Cau | |
| The party | ā | 3615 GREENPOINT R | OAD | | | 216 | | | | 10g. Citizen o | | ntry r |
| Dag St | Funeral Director | 11. Marital Status | | edent Ever in U. | S 13 1 | | | n? /Sna | city Vac or No | US | A aca - Americ | cen Indian |
| flor dea r Berns iner m | 필 | 1 Never Married 2 Married | Armed Fo | orces? | . 10. | Was Decedent of If Yes, specify Cu | ban, Mexican, | Puerto F | Rican, etc.) | В | lack, White, | |
| | by | 3 ☐ Widowed 4 ☐ Divorced | If Yes, Gi | ve | | 1□ Yes 2Ñ N | o Specify: | | | Spec | ity: WHI: | re |
| natura fisal B | | 15. Decedent's Ed | lucation | | 16a, Dece | dent's Usual Occ | upation | | | 16b. Kind of | * | |
| Media | Completed | (Specify only highest gra Elementery/Secondary (0-12) | de completed) College (| 1-4or 5.\ | (Give | kind of work don DO NOT use retii | e durina most d | of workir | ng | | | |
| the state of | E | I2 | College (| 1-401 3+) | SECRE | ETARY | | | | HIGH S | CHOOL | |
| 불물들 | Be | 17. Father's Neme (First, Middle, Last) | | | | | 18. Mother: | s Name | (First, Middle | , Maiden Sume | eme) | |
| markad c | 2 | JOHN DUSENBERRY | | | | | CORNE | ELIA | OWENS | | | |
| and la ma | | 19a. Informant's Name/Reletionship (7 | Type, Print) | | 19b. Meilir | ng Address (Stre | et a <i>nd Number</i> | or Rura | Route Numb | er, City or Tow | n, State, Zij | Code) |
| 発動なせ | | JOHN ROGER TODD/H | USBAND | | 3615 | GREENPO | INT ROA | D, I | EAST NE | EW MARK | ET, M | D 21631 |
| 主義者 | | 20a. Method of Disposition | | | lace of Dispo | sition (Neme of metory or other p | (ace) | | Date | 20c. Location | - City or To | own, State |
| nent o | | 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify | | State | - | MARKET (| | Y 8 | /24/97 | EAST 1 | NEW MA | ARKET, MD |
| Departmen important: any injury once. | 1 | 21. Signature of Furural Service Ligen | 199 | 111 | 22 | Name and Add ELLER FU | ress of Facility | | | | | |
| Depa Impo any is | 4 | Hennel | XJ- | Alle. | 4 10 | 6 MAIN | NEKAL H | DME, | P. O. | MADVET | MD. | 21631 |
| | 7 | 236. Party. Enter the disease, or only of spook, or heart failure. List only of | dications that'c | used the death | | | | | | | , 1110 | Approximate |
| hysician | 7 | good, or result lations. List pray o | one cause on | each line. | | . 1 | / | | | | | Interval Between Onset and Death |
| /Medical | | Immediate Cause (Final disease or condition | 7100 | lin- | Az | nl H | Miss | | | | - 1 | 4 mis |
| xaminer | | resulting in death) | a Crice | Due to (or | as a conseq | wenderin: | /// | | | | -+ | / |
| - | Der | ALC: Y | 200 | 200000000000000000000000000000000000000 | | | | | | | | |
| and | Examiner | Sequentially list conditions, if any, leading to immediate | в. | Due to (or | as a conseq | suence of): | | | | | - 1 | |
| | | cause. Enter Underlying | | | | | | | | | - 1 | |
| physician the buria | edical | Cause (Disease or injury that initiated events resulting in death) Last | c | Due to (or | as a conseq | uence of): | | | | | - 4 | |
| | Mec | L | an. | | | | | | | | - 1 | |
| | | | a. | | | | | | | | | |
| thed the | by Physician | Part II. Other significant conditions co | ntributing to de | eath but not resul | iting in the ur | nderlying cause g | iven in Part I. | | 23b. Did | tobacco use c | ontribute to | the cause of death |
| detay detad | E | Parking | | ELME | - | | | | 10 | Yes 2500 | 3 □ Proi | bably 4□ Unknow |
| agned b | ò | 1.7070000 | 7 1 | 3-172 | | | | _ | | | - | |
| pean s | Completed | | | | | | | | | an autopsy med? | av | ere autopey findings ailable prior to |
| has b | ğ. | | | | | | | | | | of | mpletion of cause death? |
| ate ha | 000 | | | | | | | | 101 | res 2RINO | 10 | Yes BENO |
| clor | e a | 25. Was case referred to medical examiner? | | | | | 26. Place o | d Death | (Check only o | ne) | | |
| al die | 0 | 1 □ Yes 2,55240 | Hospital: 1 □ 1 | npatient 2218 | R/Outpatien | t 3D DOA | ther: 4 Nursi | ing Hom | e 5⊡ Resid | dence 6 🗆 O | ther (Specif | y) |
| r death. ector: Atar this o | E 0 | 27. Manner of Death 1. Natural 5 □ Pending | 28s. Date (Mont | of Injury th, Day Year) | 28b. Time of Injury | 28c. Inju | ury at ork? | 2 | 6d. Describe t | now injury occu | rred | |
| death. | Certification: | 2 ☐ Accident investigation |) | | | M 1[|]Yes 2∏No | 2 | | | | |
| Birector: | Ē | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Mace | of Injury - At hor | me, farm, stre | eet, factory, office | | 2 | Bf. Location (2 City or Tox | | iber or Rure | il Route Number, |
| atte atte | | | | | | | | | | | | |
| within 24 hours To the Funeral completely filled | edical | 29e. Certifier Check only 2 Medical Exam | sician: To the | best of my know | vledge, deeth | occurred at the t | time, date end p | plece, a | nd due to the | cause(s) and n | nanner es s | tated. |
| within 24 hours all To the Funeral Dir completely filled in | | one) | and man | ner stated. | | | | 2000110 | | | | |
| To Con | 2 | 29b. Signeture and title of certifier | | | | | nse number | | | 29d. Dete sign | | |
| | | 11/1/1 | eftel | ac | MS | Do | 0638 | 8 | | 08.9 | 6-19 | 787 |
| | | 30. Name end address of person who c | ompleted caus | e of death (Item | 23a) (Type, I | Print) | 11 | / | 1 | 0 / | | |
| | | Michael FAC | Klew | MD3 | 0200 | 1/10/5 | Hour | lock | (mi | 2/6 | 543 | |
| State | ~ | 31. Dete filed (Month, Day, Yeer) | 32. R | egirtrar's Signatu | we P | 1.11 | | | | | | |
| Registra | r | AUG 2 9 | 199/ | fella di lui | man. May | VA4 | | | | | | |
| | _ | | | | _ | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth TULL Month **Physician** LOVISE MARION August 26, 1997 1:00 p.m. /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Edw. W. McCready Memorial Hospital Crisfield Somerset If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) If Under 1 Yeer 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Deys Hours 1 □ M 2 K F 72 Yrs. Director 220-26-0894 11, 1924 Maryland Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-4 show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Somerset 1 ☐ Yes 2 M No Marion Station Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21838 USA 6270 Charles Cannon Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give 14. Race - American Indien, Bieck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White þ Specify: 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Buelness/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker At Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Surname) Be Lee Riggin Elsie Brumley 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) William S. Palmer (nephew) 11930 Sherree Lane - Princess Anne, MD 21853 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from Stete St. Paul's Cemetery 8/29/97 Marion Station, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bradshaw & Sons Funeral Home 21. Signeture of Funerel Service License · Karbutt. Templem 306 W. Main St. - Crisfield, MD 21817 Robert H. Bradshaw 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical immediate Ceuse (Finel disease or condition resulting In death) Catolotspurctory Examiner Due to (or as a consequence of); Mitastatic Discesse or Attanding Physician: The law requires that the deeth certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or as e consequence of). Bregr Cermone Division of Vital Records, P.O. Box 68760, ding physician Physician/Medical Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t Congratue Heart Fadere 1 Yes 2 No 3 Probably 4 Unknown by COPD 24b. Were autopsy findings evalleble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? MEDIN 2 No 2 No this certificate 25. Wes cese referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA edical Certification: To 27. Menger of Death 28d. Describe how Injury occurred 28e. Dete of injury (Month, Dey Year) 28b. Time of After Neturel 5 Pending death. 1 ☐ Yes 2 ☐ No investigetion efter death 2 Accident In by the 3 Suicide 6 Could not be 281. Location (Street and Number or Rural Route Number, etc.) or Town, State) 28e. Place of Inlus. At home, farm, street, factory, office building. Ic. (Specify) 4 Homicide within 24 hours eft To the Funeral DI completely filled In the Hospital 16 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and plece, end due to the ceuse(s) end manner es stated.

2 Medical Examiner: On the basis of exemination and/or investigetion, in my opinion, deeth occurred at the time, date and plece, and due to the ceuse(s) end menner stated. 29a. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8.26.97 15 715 30. Name and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) ANE CRISFIELD BURTON AUG2 8 1997 July Davidson Kardall 31. Dete filed (Month, Dey, Year) State Registrar

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The same trade at the particular of the contract of the contra

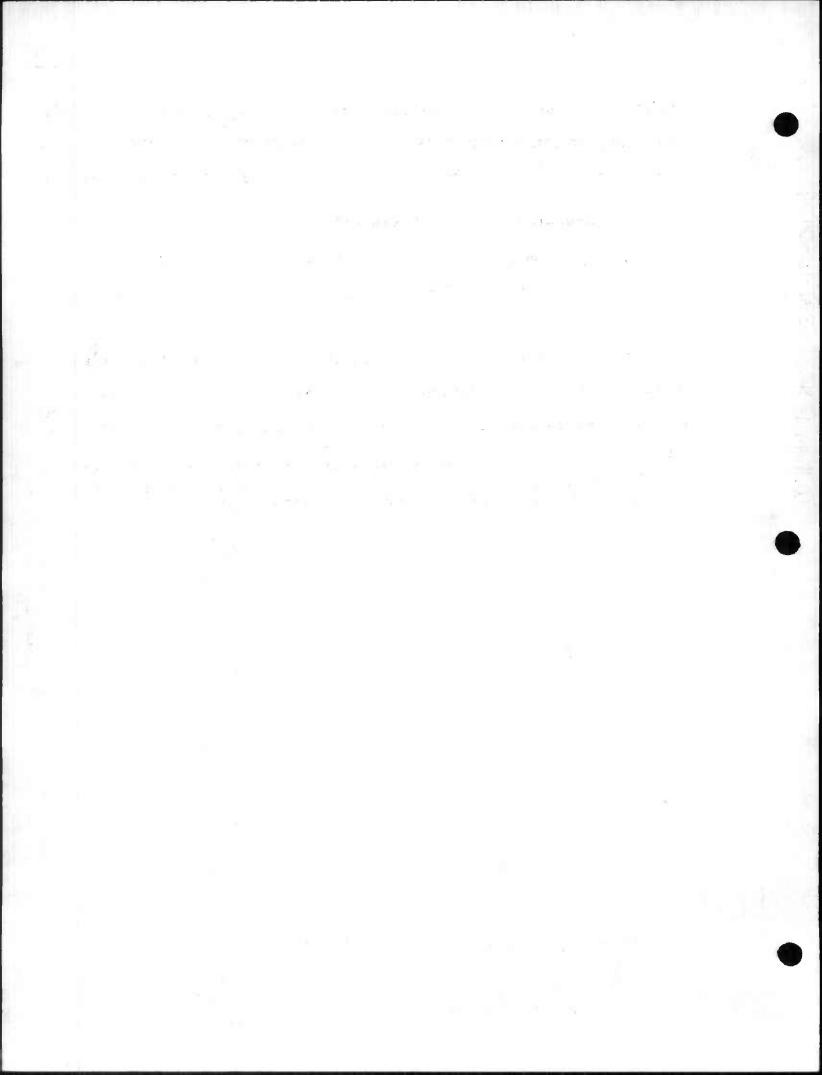
liam Usillan S79-18-2199

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 23 1821 August William Kenneth Usilton Sr. /Medical 4b. City, Town, or Location o Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M M 2 □ F Months Days Yrs. 579-18-2129 Director 76 05 15 21 Washington, D.C. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If time 21 is marked other than "natural", or items 23a or 28s-f show any Injury or other traumatic event, its Macine Examiner must be notified any Injury or other traumatic event, its Macine Examiner must be notified. 1 ☐ Yes 2 ☐ No Directo Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 136 St., Bldg. 7, Apt. 601 North 21842 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. XXYes 2□No Navy If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 3 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 r Moving Company Estimator 17. Father's Name (First, Middle, Last) Be 2 Thomas Bayard Usilton Agnes West 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21842 136 St., Bldg. 7, Apt. 601 North, Ocean City, MD
20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State Catherine Usilton-Wife 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cemetery 8/27/97 Silver Springs, MD 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Holloway Funeral Home, P.A OFSP dollow 501 Snow Hill Road, Salisbury, MD 23a. Part1. Enter the disease, or complications the consed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on which line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Asystole Minutes disease or condition resulting in death) **Examiner** bue to (or as a consequence of) Examiner Atherosclerotic cardesvascular disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, The law requires that the death certificete be Physician/Medical the Due to (or as a consequence of): signed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of geath? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of ceuse of death? 1 Yes 2 No 1 Yes 2 No certificate Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how Injury occurred 1 Natural 5 Pending Investigation death. 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide To the Hospital or within 24 hours att To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D41721 mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 PAVLOS STEPHAN 560 RIVERSIDE DR SUITE BIDI SALUBURY MD 21801 avv 32. Magistray's Signature Randell 31. Date filed (Month, Day, Year) State AUG 26 1997 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.



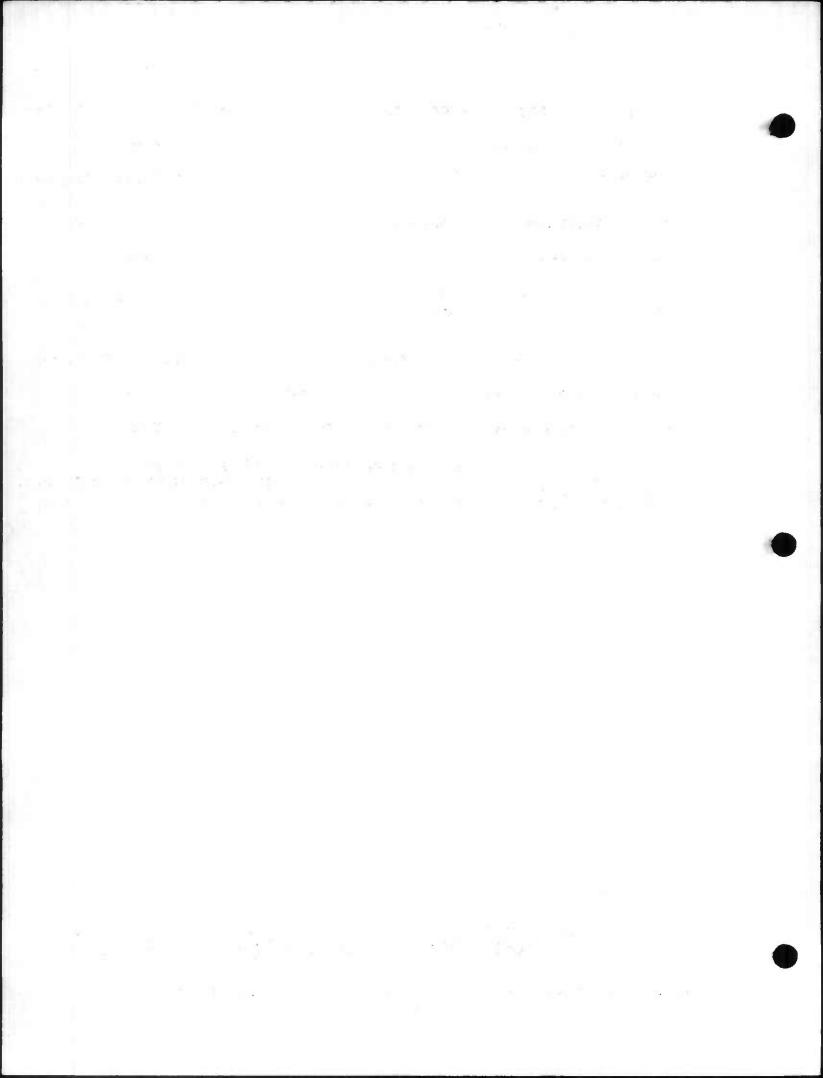
State of Maryland / Department of Health and Mental Hygiene 97

97 2710:

| | | | | | | Certi | ficate of | Death | | | Reg. No. | | E., 1 | 100 |
|---------------------|--|----------------|---|--|----------------|----------------------|------------------------------------|----------------------------------|--------------------------|--|---------------|------------------------------|----------------------|----------------------|
| | | | 1. Decedent's Neme (First, Middle, L | ast) | | | | | | 2. Date of De | eth | | 3. Tin | ne of Deeth |
| | Physici | | WOODROW EDMOND | T | RIE | | | | | Month 08 | Day 24 | Year 97 | 04 | 456 |
| N | /Medi Examir | | 4a. Fecility Neme (If not institution, g | | 1111 | | | 4b. City, To | wn, or Lo | cation of Deat | | ounty of Dee | | 130 |
| | Examili | 161 | PENINSULA REGIONA | | MTER | | | SALIS | VIII | | | OMICO | | |
| _ | - | | | | yrs. lest birt | thdev) | If Under 1 Yeer | | | 8 Date of Bir | | | thologo /Ci | nto or Foreign |
| | Funeral Director | | 216-36-7354 Usuel Residence of Decedent | 10XM 2□ F | | | Months Deys | | Min. | 8. Dete of Bir (Month, De 09-27- | 39 -39 | | imore | , MD |
| | tend w | | 10a. State 10b. County | 100 | c. City, Towr | n or Locat | tion | | | | | | 10d. Insid | de City Limits |
| | be filed within 72 hours effer death with the Maryland tal Hyglene. d other than "naturel", or Items 23a or 28a-f show event, the Medical Examiner must be notified at | Director | | omico | Fruit | т т | 10/7/0 | | | | | | | Yes 2000 |
| | Vith 1 | ä | 10e. Street and Number | | | | 10f. Zip Code | | | | 10g. Citize | n of What Co | ountry? | |
| | 23a | a | 4034 Joseph Drive | | | , | 21.8 | | | | | USA | | |
| | do ma | Funeral | 11. Marital Status | 12. Wes Decedent Ever Armed Forces? | IAVÝ | 13. We | s Decedent of I es, specify Cub | Hispenic Original en, Mexican | gin? (Spe i, Puerto l | cify Yes or No Rican, etc.) | - 14 | . Rece - Ame Bleck, White | | in, |
| Maryland 21215-0020 | ours efte | by | 1 ☐ Never Married 2 💆 Married 3 ☐ Widowed 4 ☐ Divorced | 1 Ves 2 No If Yes, Give Year or Detes:V I F | | | Yes XX No | | | | | pecify: | HITE | |
| 5-0 | 72 ho | Completed | 15. Decedent's E (Specify only highest g | Education rade completed) | 16a. | Deceden (Give kin | t's Usual Occu | pation during most | t of worki | na | 16b. Kind | of Business | /Industry | |
| 21 | within ene. | 현 | Elementary/Secondary (0-12) | College (1-4or 5+) | | life. DO | NOT use retire | ed) | | | | | | |
| 7 | filed w Hygier ther th | ပိ | 12 | 3 | S | tore | Clerk | | 111 1 2 1 1 2 | | | land ! | Sunoc | 0 |
| 밀 | al Hygi I other | Be | 17. Father's Name (First, Middle, Las | t) | | | | 18. Mothe | r's Name | (First, Middle | , Maiden St | ımame) | | |
| yla | should be and Mental I is marked of umatic even | P | Woodrow Vincent I | Jrie | | | | Hele | n El | izabeth | Madi | son | | |
| a | and and is me | | 19a. Informant's Name/Relationship | (Type, Print) | 196. | . Mailing / | Address (Stree | t and Numbe | or or Rura | l Route Numb | er, City or 1 | own, State, | Zip Code) | |
| Σ | D 5 1 2 | | Deborah Sue Urie- | -Wife | 40 | 34 J | oseph D | rive, | Fru | itland, | MD | 21826 | | |
| ore | oth oth | | 20a. Method of Disposition | | 0b. Plece of | Dispositi | on (Name of ony or other pla | ice) | | Dete | 20c. Loca | tion - City or | Town, Ste | te |
| Ĕ | permit. Pages 1 an Department of Heal Important: if Item 2 any Injury or other once. | | 1 ☐ Burial 2XXCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec | the state of the s | | • | | , | 10 | 125 107 | 0-1:- | h | MD | |
| Baltimore, | artm orta | | 21. Signeture of Fungret Service Lice | | allsu | | Cremato | | | /25/97 | | | | - D |
| ä | Depariment of the part of the | | 11PN.11 | 1 0- | 0 | | | | | llowa | - | | | |
| | _ | _ | 23a Part 1 Enter the diseases or our | mollostic from sound the | don'th Do | | l Snow | | | | | bury, | | 21804 |
| | | | 23a. Part1. Enter the disease, or cor shock, or heart failure. List only | y one cause on each line. | death. Do i | iot enter t | rie mode or dy | ing, such as | Cardiac 0 | respiratory a | 11051, | | | Between and Death |
| 0 | Physician /Medicai | | Immediate Cause (Final | | | | | | | | | | 1 | 5110 500(1) |
| | Examiner | | disease or condition resulting in death) | a ARTERIOSCI | EROTI | C_CAI | RDIOVAS | CULAR | DISE | EASE | | | | |
| | | - | | Due | to (or as a | conseque | nce of): | | | | | | | |
| | B is | Examiner | | b | | | | | | | | | | |
| | certificate be executed uding physician and use as the burial-transit | хап | Sequentially list conditions, | Due | to (or as a c | conseque | nce of): | | | | | | | |
| 68760, | cian cian | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury | C | | | | | | | | | | |
| 87 | sate l | edicai | that initiated events resulting in death) Last | Due | to (or as a c | onsequer | nce of): | | | | | | | |
| 9 x | D B | 2 | | | | | | | | | | | | |
| Bo | | an/ | | u | | | | - | | | | | | |
| | 0 0 % | Physician/ | Part II. Other significant conditions | contributing to death but no | t resulting In | the unde | orlying cause gi | ven in Pert I. | | 23b. Dld | tobacco us | s contribute | to the car | uss of death? |
| P. 0. | at the | پار ک | | | | | | | | 10 | Yes 20 | No 3□P | robably | 4 Unknown |
| ś | es the bengi | by I | | | | | | | | | | | | |
| 5 | - cr co = | 8 | | | | | | | | | an autopsy | 24b. | Were auto | psy findings |
| Record | > 10 (i) | olet | | | | | | | | perio | Jiii 100 : | | completion of death? | |
| Re | 0 - 5 | Completed | | | | | | | | 10 | Yes 2 🕅 | | 1 🗆 Yes | O No |
| Vital | ician: Th | | 25. Was case referred to medical | T | | | | on Disease | -4 D=-44 | | | 140 | 1 🗀 1 63 | 20140 |
| 5 | Physician: this certific | o Be | examiner? 1 ☑ Yes 2 ☐ No | Hospital: | · Menio | | on Do | hor | | (Check only | | 700 00 | | - |
| ō | Phys this rel di | . To | 27, Manner of Death | 1 ☐ Inpatient | 2 XER/Out | ime of | 3LI DOA | 4 🗆 140 | | ne 5 Resi | | | city) | |
| E C | Attending I or death. ector: After by the funer | HOI | 1 XNatural 5 ☐ Pending | (Month, Day Yes | | njury | 28c. Inju Wo | rk?]Yes 2⊟i | | | | | | |
| S | death ctor: A | Ica | 3 ☐ Suicide 6 ☐ Could not | De Disea of Injury | At home do | | | 100 201 | | 28f. Location (| Street and | Mumber or D | ural Pouta | Alumbar |
| Division | or Attendation of the office o | Certification: | 4 Homicide determined | 28e. Place of Injury - building, etc. (S) | pecify) | nn, street | , tactory, office | | 1 | City or To | | vunibal of M | urar noure | Number, |
| _ | urs urs mal f | | | | | | | | | | | | | |
| | Hose 24 ho Fun Fun | edicai | | hysician: To the best of my miner: On the basis of examiners | | | | | | | | | | 19 e (s) |
| | To the Hospital or / within 24 hours after To the Funeral Director Completely filled in b | Me | 29b. Signeture end title of certifier | and manner stated. | | | 29c. Licen | se number | | | 29d. Dete | signed (Mont | th, Dey, Ye | ar) |
| | | | D1 | 11 5 | _ | · - | 50055 | | | | 00 0 | 0.5 | | |
| | NA | - | Johno | hopselfor | | M.E. | D0359 | 19 | | | 08–24 | - 97 | | **** |
| | 1×118 | | 30. Name and address of person who | | | | , | | | U | | | | |
| | | | JOHN T. BULKELEY 31. Date filed (Month, Day, Year) | , M.D., 108 F | | LUFF | ROAD, | SALISI | BURY | MD 218 | OT | | | |
| | Sta Registr | | AUG 26.19 | | Geor-Ra | dall | | | | | | | | |
| | riegisti | 911 | 4 % 6 10 | ~ / / · | | | | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene 97

| | | | | | | Certificate | of Death | R | Reg. No. | 1 61 | 104 |
|-----------------|---|----------------|--|--|---------------------|--|--|-----------------------------------|-------------------|---------------------------|--|
| | | | 1. Decedent's Neme (First, Middle, L. | ist) | | | | 2. Dete of Des | th | | Time of Deeth |
| | Physic /Medi | | MATHIAS | LEO WI | NKEL | JR. | | Month 0.8 2 | 24 97 | Yser | 8:40am |
| | Exami | | 4e. Fecility Neme (If not Institution, gi | | | | 4b. City, Town, or Lo | ocation of Death | 4c. County | of Deeth | |
| 7 | Exami | | ATLANTIC GENER | AL HOSPITA | Τ. | | Berlin | | Word | ester | |
| | Funeral | | | | yrs. lest bir | thdey) If Under 1 Y | ear If Under 24 Hrs. | 8. Dete of Birth (Month, Dey | | | Stete or Foreign |
| Ш | Director | | 215-09-7924 | 1 M 2□F 8 | 0 | Yrs. Months D | eys Hours Min. | 05 18 | | Country) | |
| | D | | Usuel Residence of Decedent | | | | | 0.5.10 | | artimor | C) III |
| | how how | | 10a. Stete 10b. County | 100 | . City, Tow | n or Location | | | | | side City Limits |
| | o Ma | cto | MD Baltim | ore | Balt | imore | | | | 1-1-1 | Yes 2 No |
| | th 20 | Director | 10e. Street and Number | | | 10f. Zip Co | de | 1 | l0g. Citizen of W | first Country? | |
| | 23a | | 108 W. 39th Str | eet | | | | | US | A | |
| | 72 hours after death with the Maryland "natural", or flams 23a or 28a-f show adical Examiner.must be notified at | Funeral | 11. Merital Stetus | 12. Wes Decedent Ever Armed Forces? | in U,S. | 13. Was Decedent | of Hispanic Origin? (Sp. Cuban, Mexican, Puerto | ecify Yes or No- | | - American Inc | lien, |
| 0 | or h | | 1 Never Merried 2 Merried | xt Yes 2 No C If Yes, Give Yeer or Detes Gua | oast | 1 ☐ Yes 2/⊡ | | nican, etc.) | | White, etc. | |
| 21215-0020 | ral". | l by | 3√3√Widowed 4 □ Divorced | Yeer or Detes Gua | rd WWTT | ILL 168 EXT | кчо эрвспу. | | Specify: | MILLE | |
| 5-0 | 72 h | Completed | 15. Decedent's E (Specify only highest gr | ducation | 16a. | Decedent's Usual O | ccupation lone during most of work | ina | 16b. Kind of Bus | siness/Industry | |
| 21 | 2 . 5 2 | nple | Elementery/Secondery (0-12) | College (1-4or 5+) | | life. DO NOT use r | etired) | "'y | | | |
| | 73 00 6 | S | 11 | 4 | | Owner | | | Brick M | lanufact | turing |
| pu | be file ntal Hys d othe avent, | Be | 17. Fether's Neme (First, Middle, Las | ") | | | 18. Mother's Neme | e (First, Middle, I | Meiden Surneme | 9) | |
| ya | | 2 | Mathias Leo | Winkel Sr | | | Emma | | E | lownes | |
| Maryland | | | 19e. Informent's Neme/Reletionship | (Type, Print) | 19b | . Melling Address (S | treet end Number or Run | al Route Number | r, City or Town, | State, Zip Code |) |
| | Heelth Heelth Jem 27 i | | Peggy L. Sculle | y-Daughter | 95 | 30 Leemay | Street, Vi | enna, VA | A 221.82 | | |
| ore | T tet | | 20e. Method of Disposition | 20 | b. Plece of | Disposition (Name or, cremetory or other | of | | 20c. Location - 0 | | tete |
| Ĕ | Peges nent of I int: If its | | 1 ☐ Buriel 2/13/Cremetion 3 ☐ 4 ☐ Donstion 5 ☐ Other (Speci | | | ury Crema | 1 | /26/97 9 | Salichur | T MD | |
| Baltimore, | 교원론증 . | | 21. Signeture of Funeral Service Live | | 1 | 22. Neme end A | ddress of Fecility HOI | | | | E. P.A |
| m | Depa Impo | | 1/1/D/K/ | 11 6 | CESP | | | | | | |
| | _ | | 23e. Pert1. Enter the disease, or con | policetions that caused the | - | 501 Snov | W Hill Roa | ad, Sal | lisbury | | 21804 oximate |
| | Dhualalan | 0.0 | 23e. Pert1. Enter the diseese, or con shock, or heart feilure. List only | one cause on each line. | | ing of the first the second | aying, outli do outlido | or respiratory on | 001, | Inten | oximete val Between et and Deeth |
| | Physician /Medical | | Immediate Cause (Final | 2 2 | | | | | | W | 000 |
| | Examiner | | disease or condition resulting in deeth) | S 950 | | | | | | 7 | dey |
| | | - | | A.L. ODue | to (or as a | sequence of): | | | | | |
| | nsit n | Examiner | | b. fleer | - 11 | voin | | | | 40 | lagg |
| - 6 | and and | xai | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due | to (or as 🕯 | consequence of): | | | | 10- | 200 |
| 9 | icate be executed physician and s the buriel-transit | | Cause (Disease or injury that initiated events | 0000 | | | | | | re | MYCS |
| 68760, | the deeth certificate be executed by the attending physician and ached for use as the buriel-transit | Medical | resulting in death) Last | Due | o (or es s o | consequence of): | | | | | |
| | n certifica anding pl use as t | | | d | | | | | | | |
| Box | attendi for use | Physician/ | | | | | | | | | |
| 0 | that the deeth ned by the atter detached for o | Ys | Pert II. Other significant conditions | contributing to death but not | resulting in | the underlying caus | e given in Pert I. | 23b. Did to | obacco use con | 1 | ause of death? |
| Q | | | | | | | | 1 □ Y | 'es 2□ No | Probably | 4 Unknown |
| ds, | w requires that been signed I should be det | by | | | | | | 1.0 | and the same of | 045 1465 - | |
| 0 | requires seen sign | ě | | | | | | 24e. Wss a perform | | 24b. Were au available | prior to |
| ec | E 2 C4 | pidu | | | | | | | , | of deeth' | on of cause ? |
| E | The Laste has page | Completed | | | | | | 1□ Ye | es To No | 1 🗆 Yes | 2□ No |
| ita | ysician: The s certificate director, pag | Be (| 25. Wes case referred to medical examiner? | | | | 26. Place of Desti | h (Check only on | 10) | | |
| of Vital Record | 0 0 | Tol | 1 Yes 20 No | Hospitel: Inpatient | 2 ☐ ER/Ou | tpatient 3 DOA | Other: 4 Nursing Ho | me 5 Reside | ence 8 Othe | r (Specify) | |
| 0 | g Ph | | 27. Mender of Death | 28e. Dete of Injury (Month, Dey Yea | | Time of 28c. | Injury et Work? | 28d. Describe ho | ow injury occurre | ed | |
| <u>ō</u> | or Attending latter death. Director: After 5 in by the funer | atlc | 1 Naturel 5 ☐ Pending 2 ☐ Accident investigation | n | , | M | 1 ☐ Yes 2 ☐ No | | | | |
| Division | er de | ti fic | 3 Suicide 6 Could not be determined | 28e. Pleca of Injury - in building, etc. (Sp | | rm, street, fectory, of | fice | 28f. Location (St City or Town | | er or Rural Rout | le Number, |
| | a after | Certification: | 1 | building, etc. (b) | oury) | | | ony or row | 11, 0.010) | | |
| | hour hour mer ly fill | | 29e. Certifier 1 Certifying Pt | ysician: To the best of my | knowledge | , deeth occurred at ti | ne time, dete end plece, | end due to the ca | ause(s) and mer | nner as stated. | |
| | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | edical | (Check only 2 Medical Examone) | niner: On the basis of exar end menner steted. | ninetion en | ovor investigetion, in | my opinion, deeth occurr | ed et the time, d | lete and plece, s | nd due to the c | ause(s) |
| | To the To the Com | Σ | 29b. Signature and title of certifler | 10. | | 29c. Li | cense number | 2 | 9d. Dete signed | (Month, Day,) | (ear) |
| | | | 125h Ca | ers " | 2 | D | 17676 | 0 | 8/21 | 415: | + |
| , | VP | 1 | 30. Name and address of person who | completed cause of deeth | Item 23a) / | Type, Print) | 1,0,4 | | | - | |
| 1 | 14, | | 7 | | | | | *** | 01000 | | |
| | Sta | te | Bsher Touleimat 31. Dete filed (Month, Dey, Year) | 32. Registre#s S | igne ko re 🕹 | way Dri | ve, Berlin | ı, MD | 21811 | | |
| | Registr | | AUG 261997 | 32. Registrens S | n-hard | 24 | | | | | |



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2 Date of Death 3. Time of Death Month **Physician** Boddie Lee Whittaker 97 5:25 Am 8 21-/Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Waterview Healthcare Center Salisbury Wicomico If Undar 1 Yaar 7. Aga (In yrs. last birthday). If Undar 24 Hrs. 8 Data of Birth Day 2 earl 917 9. Birthplaca (Stata or Foraign Country) **Funeral** 391-24-4229 Months 1□M 2 F Days Hours Yrs. Director Tenn. Usual Rasidance of Dacedant the Marylend 10a. Stata 10b. County 7 is marked other than "natural", or Items 23s or 28a-f show traumatic event, its Medical Examiner must be notified at 10c. City. Town or Location 10d. Insida City Limits 1 Yas 2 No Director Maryland Wicomico Salisbury 10g. Citizen of What Country? death with 681 Fitzwater Street 21801 U.S.A Funeral 19. Marital Status 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 No Was Decadant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. permit. Peges 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any Injury or other traumatic event. 1 ☐ Navar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: If Yas, Giva Yaar or Datas: þ 3 Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education 16b. Kind of Businass/Industry (Specify only highast grada completed) Elamantary/Secondary (0-12) Collaga (1-4or 5+) 9 Domestic None 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be James Murphy 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Coda) 4719 W. Leon Ter. Milwaukee, Wis. 53212

a of Disposition (Nama of place)

atary, cramatory or other place)

Data 20c. Location - City or Town, Stata Minnie Jackson 20a. Mathod of Disposition
1 □ Burlal 2 N Cramation 3 □ Ramoval from Stata 20b. Ptaca of Disposition (Nama of cematary, cramatory or other place) 4 □ Donation 5 □ Othar (Specify) Salisbury Crematory Salisbury, Md-21. Signatura of Funaral Sarvica Licensaa 22. Nama and Address of Facility
Stewart Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Baty Onsat and Daath Physician /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Examiner bunel-transit Sequantially list conditions, if any, leading to Immadiata causa. Enter Underlying Causa (Disaasa or Injury that initiated evants pue Box 68760, physician certificete be Physician/Medicai the Dua to (or as a consequence of) rasulting in daath) Last 88 9Sn 6 signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings availabla prior to completion of causa of daath? 24a. Was an autopsy performed? peen s Completed hes pege 2 certificate 1 Tas 2 No 1 ☐ Yas 2 ☐ No director, 25. Was casa rafarred to medical axaminar?
1 ☐ Yas 2 No Be 26. Placa of Daath (Chack only ona) Hospital: 1 | Inpatiant 2 | ER/Outpatient 3 | DOA 70 Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) this 28a. Data of Injury (Month, Day Yaar) unerai 27. Mannar of Daath 28b. Tima of Injury 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? i or Attending Petter death. : After t 5 Panding Invastigation 1 Matural 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not ba 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Sulcida 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify) 3 4 Homicida 24 hours efter Funeral Dire-letely filled in b Hospital 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

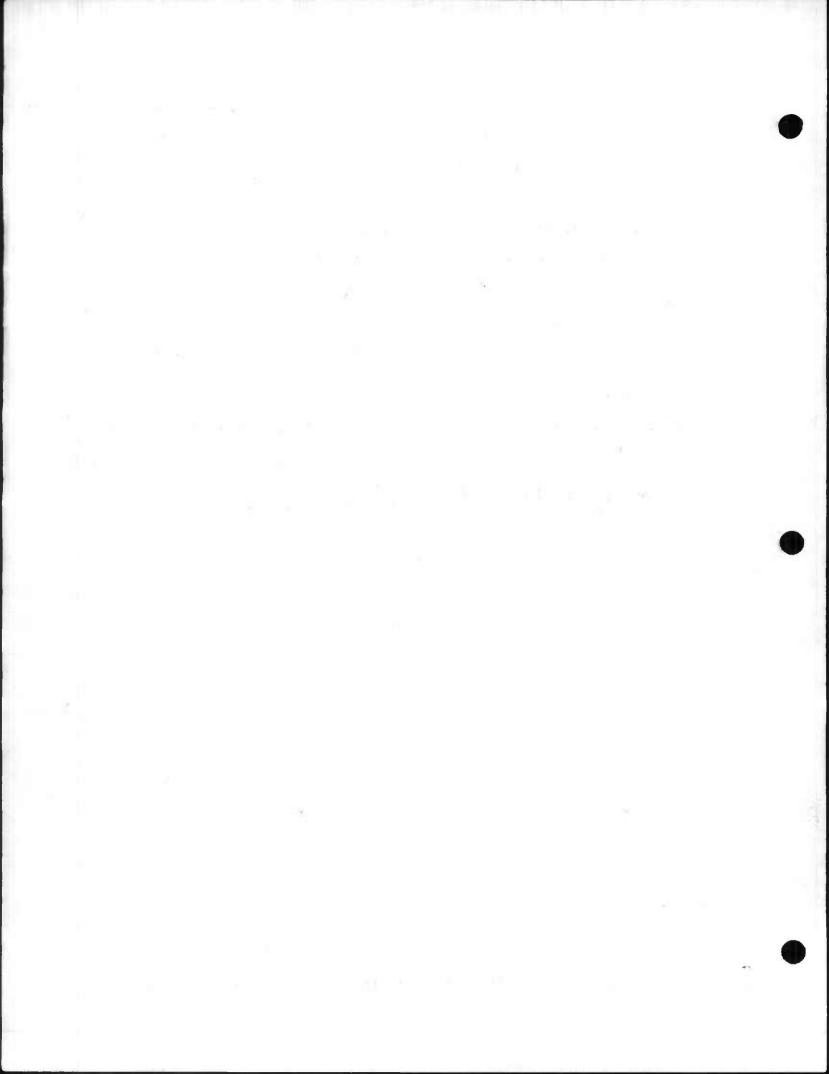
| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. Medical 29a. Cartifiar (Check only one) within 2 the 29b. Signatura and titla of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Nama and addrass of parson who completed causa of daath (Itam 23a) (Type, Print) 3 DR. WILLIAM ROBINS 1104 HEALTHWAY DRIVE SALISBURY, MD. 21801 31. Data filed (Month, Day, Year) 32. Ragistrar's Signatura

Registrar **DHMH 16 Rev 6/95**

State

AUG 26 1997

Talia Davidson Rardall



State of Maryland / Department of Health and Mental Hygiene

If Under 1 Yaar

Certificate of Death 2. Date of Death 3. Time of Death White 1997 4, 1997 4c. County of Death 4b. City, Town, or Location of Death 8:50 PM 4a. Facility Name (If not institution, give street end number)

Salisbury, MD

If Undar 24 Hrs.

Wicomico

9. Birthplace (State or Foreign

Physician /Medical **Examiner**

1. Decedent's Nama (First, Middle, Last)

Salisbury Center: Genesis ElderCare

Irene

5. Social Security Number

Funeral

Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland neat of Health and Mental Hyglens. and the first and Mental Hyglens. and the first 21 a marked other than "naturel", or items 23a or 28a-f show any or other traumatic event, the Mendral Exertines must be notified at

21215-0020

Baltimore, Maryland

Department of Important: If any injury or once. **Physician** /Medical Examiner

The law requires that the death certificate be executed P.O. Box 68760, tha attanding physician been signed by the attai Division of Vital Records, Aftar this cartificate has Attending Physician:

To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral (

1□M 20 F Hours 212-14-4932 Director Usual Residence of Decadent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Wicomico 1 ☐ Yas 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 262 Sexa/ 12. Was Decedant Ever in U,S. Armed Forces 1 ☐ Yas No If Yes, Give Yaar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - Amarican Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 1akex 17. Fathar's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Meiden Sumema) Be Informant's Name/Rejationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 2, 1207 Randolph ixde, Pikesville 22 20b. Placa of Disposition (Name of cemetary, cremetory or other) 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funerai Sarvice Licensee 400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate ntervai Baty Onset and Death Immediate Cause (Final Monono disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Physician/Medical Dua to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown by Be Completed 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 No 25. Was case referred to medicel examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes 3 Suicide 6 Could not be determined 28f. Location (Streat end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 29a. Certifier Medicai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and title of certifiar 29c. Licansa number 29d. Data signad (Month, Dey, Year) 15/90 un D39813 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

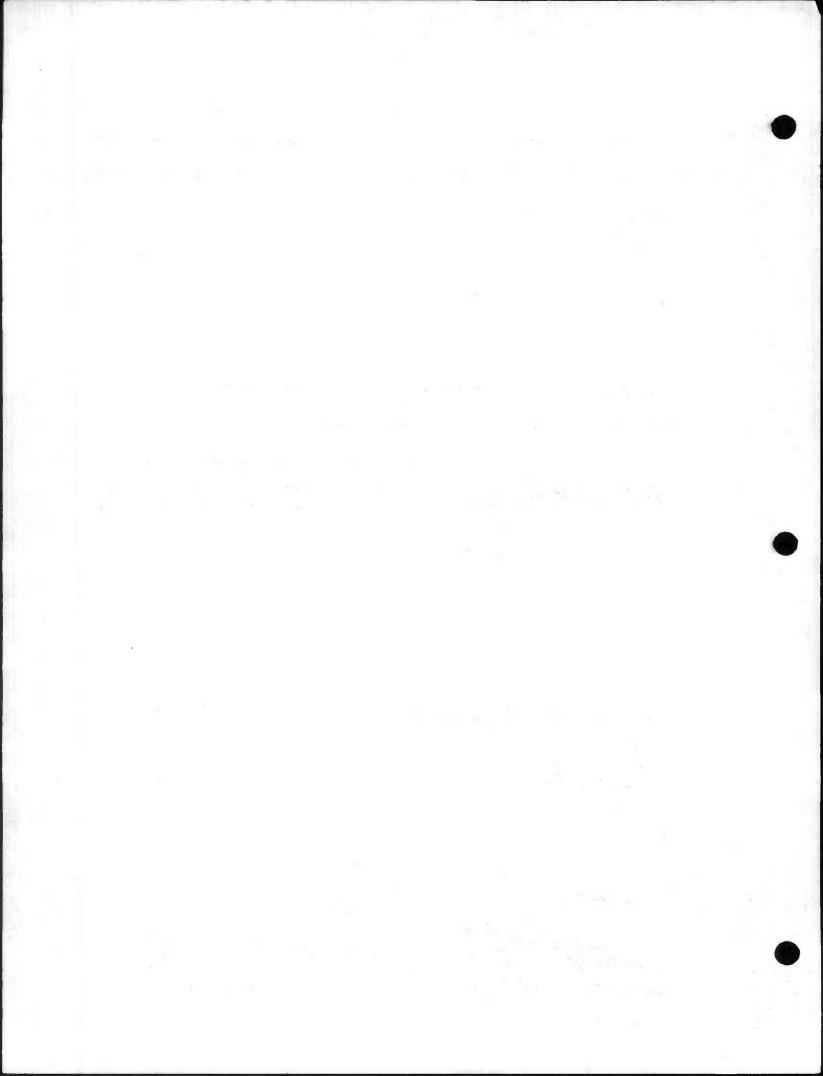
1104 Healthway Dr., Salisbury, MD

DHMH 16 Ray 6/95

State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Dete of Deeth **Physician** Month Dey 1997 6:45 AM August 7, Marguerite Winnie /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner St. Mary's Nursing Center Leonardtown St. Mary's If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 1□M 25 F 577-22-5124 Yrs Director 98 May 21, Connecticut Usuel Residence of Decedent death with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Maryland St. Mary's Hollywood 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20636 Rt. 3 Box 603 U.S.A. Funeral Hems 11. Maritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bieck, White, etc. other treumatic event, the Medical Examiner. nit. Peges 1 and 2 should be filed within 72 hours efter terterment of Health and Mental Hygiene. ortant: If Item 27 is marked other than "natural; or item injury or other traumatic event, the Medical Examina 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify. White þ 3 ₩ Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Induatry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker 8 Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tischenbach Elizabeth Gardner Nicholas 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) William Winnie/Son 3806 Parkside Dr., Baltimore, MD 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Department of Important: If eny Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery 8/11/97 Arlington, Virginia 21. Signature of Funerel Service Licensee 22. Neme end Address of Fecility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland Jardener 20650 Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory arrest, or heert failure. List only one ceuse on eech line. Approximete Intervel Between Onset end Deeth **Physician** /Medicai Immediate Ceuse (Finel diseese or condition resuiting in deeth) Examiner Due to (or es e consequence of) Examiner physician and the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in deeth) Lest Due to (or es e consequence of): Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of): attending ŏ ed by the a Part II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 No been signed by should be detac 1 Yee 3 Probably 4 Unknown þ 24b. Were autopsy findings aveilable prior to completion of ceuse of deeth? 24e. Wea en eutopsy performed? Completed certificate Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica funeral director, 25. Was case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) 1 Yes 21 No 27. Manner of Death Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 DOA Certification: 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et . Work? 28d. Describe how injury occurred Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Sulcide Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital or within 24 hours a To the Funeral D 29e. Certifier Descritiving Physicien: To the best of my knowledge, death occurred et the time, dete end place, and due to the cause(s) and manner as stated. Medicai Medical Examiner: 10 the best of ny knowledge, death occurred at the time, date and place, and the best of ny knowledge, death occurred at the time, date and place, and the couse(s) and the couse(s) and the couse (s) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and address of pe n who como se of death (Item 23a) (Type, Print) Boyd, M. D California, MD 20619 July a huden Randall State AUG 8 Registrar

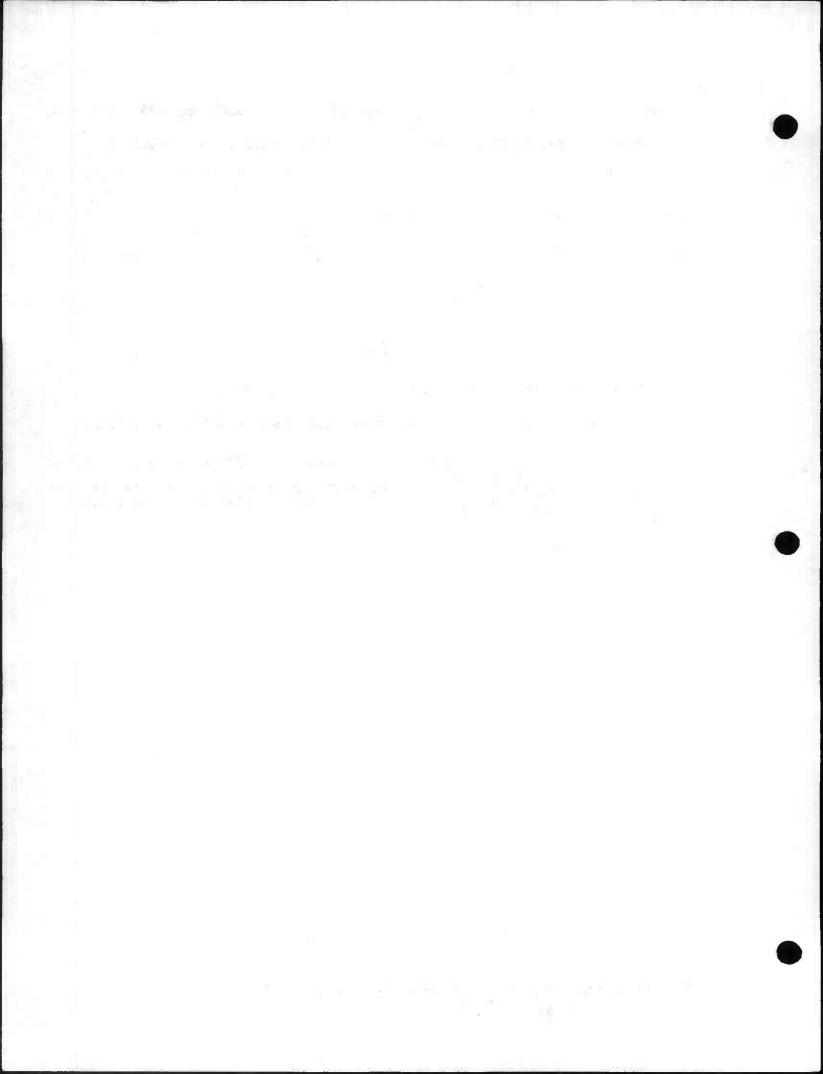


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2 Date of Deeth Day **Physician** DONNA MICHELE WATKINS 22,1997 AUG. 9:44 AM /Medicai 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SALISBURY CENTER: GENESIS ELDERCARE SALISBURY, MD. WICOMICO 8. Date of Birth (Month, Day, If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funerai** 1□M 2♥F Months Days Hours Min Yrs. 521-40-2050 NEBRASKA Director 65 AUG. 12, 1932 Usual Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MARYLAND WICOMICO PITTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with b 4662 POWELLVILLE ROAD items 23a 21850 USA death Funeral permit. Fages 1 and 2 should be filed within 72 hours after deat Department of Heelth and Mental Hygiene.
Important if them 27 is marked other than 2006. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Americen Indian, Black, White, etc. 11. Meritel Stelus 1 Never Married 2 Married 1 Yes 2 No Specify: by 3 Widowed 4 Divorced WHITE Completed 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 INSTRUCTOR MUSIC STORE 17. Father's Name (First Middle Lest) 18. Mother's Neme (First, Middla, Maidan Sumama) Be (FIRST NAME UNKNOWN) **GUTSCHER** (UNKNOWN) 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) THOMAS E. WATKINS/SON 4662 POWELLVILLE ROAD, PITTSVILLE, MD 21850 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Bunal 2 ☐ Cremetion 3 ☐ Removal from State 4 Donation Other (Spacify) SALISBURY CREMATORY 8/23/97 SALISBURY, MARYLAND 22. Name and Address of Facility
ZELLER FUNERAL HOME, 1212 OLD OCEAN CITY ROAD Marai Service Licenses P. O. BOX 3171, SALISBURY, MARYLAND 21802 Enter the diseese, or com, or heert tailure. List only ne cause on aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Onset end Death **Physician** /Medicai Immediate Cause (Final disease or condition resulting in death) **Examiner** Due to (or es e consequence of) Examiner bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest and Due to (or es e consequence of) physician the bunal Box 68760 Physician/Medical Due to (or es e consequence of). ettending p for use es ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. P.0. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ₺ Unknown signed b Records, þ cete has been sig 24b. Were autopsy tindings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificete Division of Vital Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifice stelly filled in by the funeral director, p Be 25. Was cese referred to medicel examiner? 26. Place of Death (Check only ona) Other: 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Yaar) Certification: 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 1 Natural 5 Pending Injury 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, ferm, street, factory, office building, etc. (Spacify) Localion (Straet and Number or Rural Routa Number, City or Town, Stata) 4 Homlcide To the Hospital or within 24 hours aft To the Funeral Discompletely filled in caj 29a. Certifier 1 🖰 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and manner stated. Medi 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) WILLIAM ROBINS, M.D. 1104 HEALTHWAY DR., SALISBURY, MD. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 9 199

DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** August 15, Bernice J. Ward 8:10 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Salisbury Center: Genesis ElderCare Salisbury, MD Wicomico If Under 1 Year | If Under 24 Hrs. | Months | Deys | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2**X**F Deys Director 97 215-44-7186 Dec. 28, 1899 Maryland Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 200 No Maryland Somerset Crisfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3371 Sackertown Road 21817 U.S.A. 12. Was Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Memled 2 Memied 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 18b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Grade 8 Homemaker At Home 17. Father's Neme (First, Mida e, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) permit. Peges 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e Stoughton Sterling Willie Milbourne 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1311 Taney Avenue - Salisbury, MD 21801
of Disposition (Name of Dete 20c. Location - City or Town, State Mable C. Thomas (Daughter) 20b. Pieca of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 1 XBurial 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) Asbury Cemetery 8/19/97 Crisfield, MD eut Service Lio 22. Neme end Address of Fecility Bradshaw & Sons Funeral Hom 306 W. Main St. - Crisfield, 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only one cause on each line. Bradshaw & Sons Funeral Home 306 W. Main St.- Crisfield, MD 21817 Approximete Intervel Between Onset and Death **Physician** /Medical Immediete Ceuse (Finel disease or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Box 68760. Physician/Medical Due to (or es e consequence of) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco uee contributa to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evelleble prior to completion of cause of deeth? 24e. Wes en autopsy performed? Completed peen has 2 No 1 Yes 28 No certificate the Hospital or Attending Physician: Be 25. Was case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 0 1 Inpatient 2 ER/Outpetient 3 DOA this 28c. Injury et Work? 28a. Dete of tnjury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred edical Certification: After 5 Pending investigation 1 Neturel death. 1 ☐ Yes 2 ☐ No Accident Director: 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours aft To the Funeral DI completaly filled in 1/2 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) end menner stated. 29e. Certifier (Check only one) 29b. Signeture and title of cartifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

1104 Healthway Dr., Salisbury, MD

State Registrar MATIKINS

31. Dete filed (Month, Day, Year)

1997 Julia danulum Radall

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #17, 19a, 8/15/97, BMW, Mont.Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SARA Month Year ABRAMSON August 8, 1997 3:28 PM /Medicai 4a. Facility Nama (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hebrew Home of Greater Washington Rockville Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Yaar 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 21 F Days Director 578-52-9013 Yrs June 17, 1908 Roumania Usual Residenca of Daceden 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show the Medical Examiner must be notified Director 1⊞ Yes 2□ No Maryland Montgomery Rockville tha 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 238 6121 Montrose Rd. 20852 United States daath Herra 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Give 11. Marital Status Was Dacedent of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Bleck, White, etc. aftar 1 Nevar Married 2 Married ** Baltimore, Maryland 21215-0020 ò 1 ☐ Yes 2 ☑ No Specify: White A Specify: 3 ₩idowed 4 Divorced "natural", Completed 15. Decedant's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pagas 1 and 2 should be filed within Departmant of Haalih and Mental Hygiena. Important: if item 27 is marked other than 1 any fijury or other traumatic event, the Magnita Police. Elementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middla, Last)
MOTTIS Abramson 18. Mothar's Name (First, Middle, Maiden Sumame) Be -Morria Abramson Dora Kohn 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Marvin Abramson 824 Fordham St., Rockville, MD. 20850 Marvin Abramson (Son) 20b. Placa of Disposition (Neme of cametary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 8-10-97 Falls Church, Virginia King David Mem. Gdns. 21. Signature of Funerel Service Licenses 22. Name and Address of Facilit Danzansky-Goldberg Mem. Chapels, Inc. 1170 Rockvile Pike, Rockville, MD. 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heer feilure. List only one cause on each line. Approximate Interval Between **Physician** Onset and Death /Medical Immediata Cause (Final AR DIOMYDPATHY disease or condition resulting in death) **Examiner** Due to (or as a consequence of Examiner CORONARY sician and burial-transit The law requires that the death cartificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Physician/Medicai tha Due to (or as a consequenca of) USB BS Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably ♦ Unknown 1 ☐ Yes 2 ☐ No DEMENTIA MULTI-INFARCT þ 8 24b. Were eutopsy findings available prior to Completed 24a. Was an autopsy completion of causa of death? carlificata has 1 Yes 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica completaly filled in by the funeral director, Be 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Date of Injury (Month, Dev Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

5 Pending investigation 6 Could not be determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of Chaifier

Allerding Physician

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6121 MONTROSE Rockville, MD 20852 RD, ATEL 1997 32. Register, Signature
Jundson-Randall

State Registrar

Medicai

Box 68760.

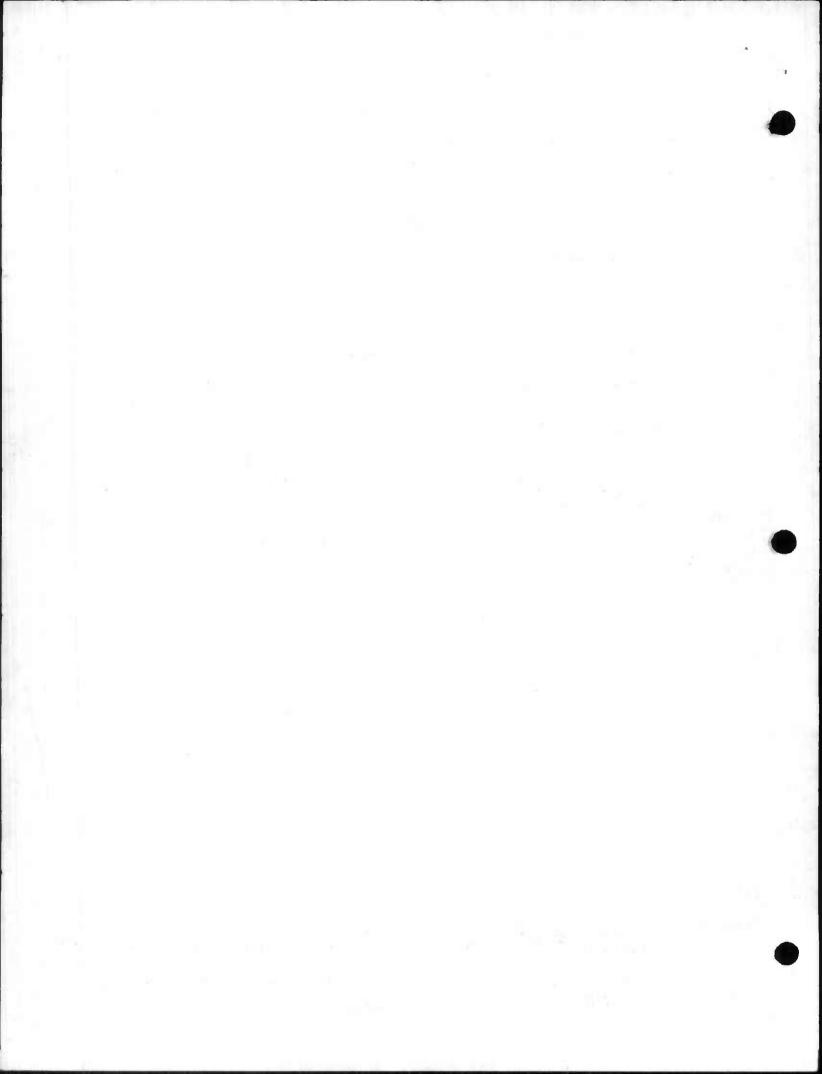
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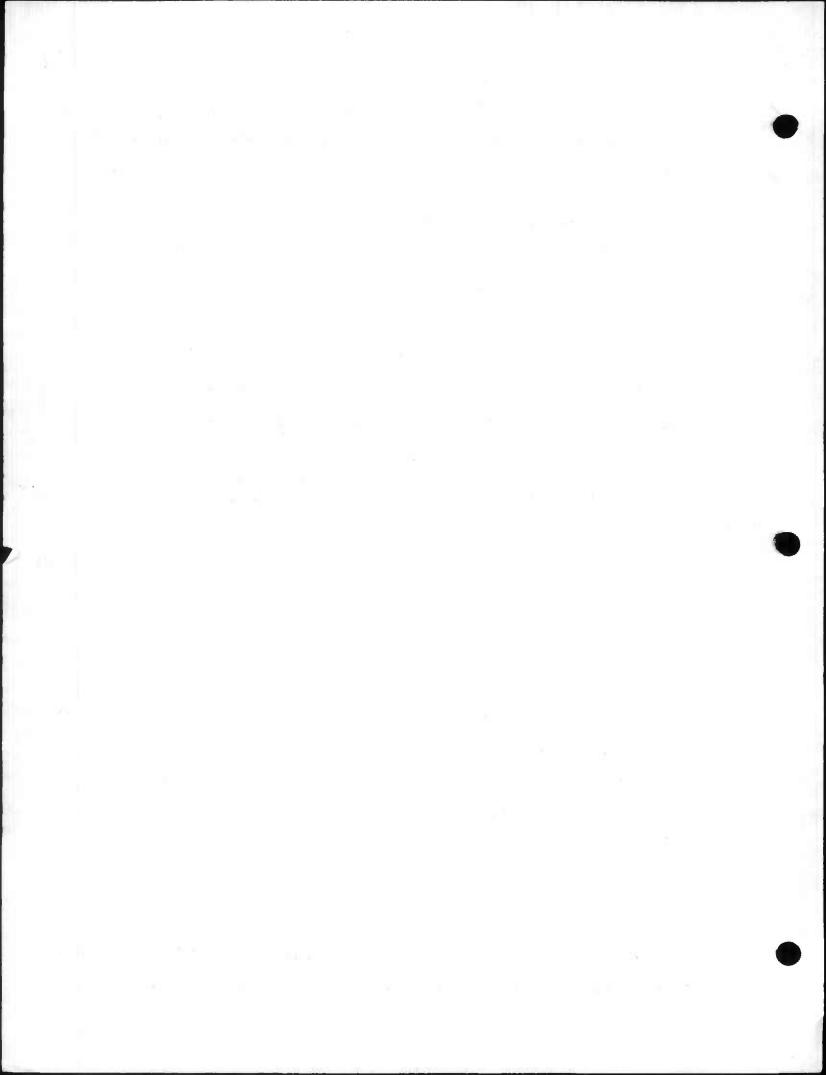
of

Division



State of Maryland / Department of Health and Mental Hygiene Q 7

| | | | | | Certificate of | f Death | P | leg. No. | 4 | 1111 |
|--|-----------------|--|--|--|--|--|---|--------------------------------------|---------------------------------|---|
| Dhysial | | 1. Decedent's Name (First, Mide | dle, Last) | | | | 2. Date of Dea Month | | Year | 3. Time of Death |
| Physici /Medic | | PETROS | | | ASTKI | | AUGUST | 19,199 | | 3:50 a.m |
| Examin | | 4a. Facility Name (If not institution WASHINGTON AD | | , | | 4b. City, Town, or L TAKOMA PA | ocation of Death | 4c. County of | of Death | |
| Funeral Director | | 5. Social Security Number None | 6. Sex 7. 1 M 2 □ F | Age (In yrs. last b | Yrs. If Under 1 Ye Months Day | | 8. Date of Birth (Month, Day July 1 | 2, 1943 | 9. Birthple Counti Eth: | ace (State or Foreign Popia |
| pud * | | Usual Residence of Decedant 10a. State 10b. Count | w | 10c City Toy | vn or Location | | | | | |
| show | 5 | The state of the s | | | | | | | 10 | d. Inside City Limits X□ Yes 2□ No |
| he N | Director | | gomery | SIIVE | r Spring | | | | | |
| 23a or 2 | ral Dir | 10e. Street and Number 75 Wayne Aven | | | 10f. Zip Code | 0901 | 1 | Og. Citizen of W Ethiopi | | y? |
| be filed within 72 hours after death with the Meryland ital Hyglene. or other than "natural", or items 23a or 28a-f show event, the Modical Examinat must be notified at | d by Funeral | 11. Marital Status 1 Never Married 2 Maria 3 Widowed 4 Divorce | If Yes Give | | 13. Was Decedent of If Yes, specify C | of Hispanic Origin? (Spuban, Mexican, Puerto Specify: | pecify Yes or No- Rican, etc.) | Black | - America k, White, e Bla | tc. |
| 72 h | etec | 15. Decede | nt's Education est grade completed) | 168 | . Decedent's Usual Occ | cupation | kina | 16b. Kind of Bus | Iness/Indu | ustry |
| within ena. than | Completed | Elementary/Secondary (0-12) | College (1-4 | or 5+) | (Give kind of work dor life. DO NOT use ret Purser | ired) | | Ethiopia | an Ai | r |
| il Hygie other | Bec | 17. Father's Name (First, Middle | , Last) | | | 18. Mother's Nam | ne (First, Middle, i | Maiden Sumame |) | |
| 2 should be filed and Mental Hygi Is merked other aumatic event, II | ToB | Astku G/Kidan | e | | | Samrawit | t W/Mari | am | | |
| 1 end 2 should the Health and Menter to worker traumatic to the traumatic to the traumatic that the traumati | | 19a. Informant's Name/Relation | ship (Type, Print) | 191 | b. Mailing Address (Stre | et and Number or Ru | ral Route Number | r, City or Town, S | State, Zip C | Code) |
| nd 2 lith a 27 Is r tra | | Mesfin Teferr | a Brother | | 7513 Maple | | | | | |
| 8 = 5 | | 20a. Method of Disposition 1 | 3 □Removal from Sta | 20b. Place of cemete | of Disposition (Name of bry, crematory or other p | olace) | Date | 20c. Location - C Silver S | City or Tow | m, State |
| permit. Pages 1 en Department of Heal Important: If Item 2 any Injury or other ances. | | 21. Signature of Funeral Service | | 1 | Mc Carried ad | unefaily Ser | rvice, I | nc. | | |
| 00200 | | 23a Part1. Epter the disease, of shock, or heart failure. Lis | w.C.N. | auco | | gia Ave. 1 | | _ | 1, D. | C. 20012 |
| reflicate be executed by the physician and as the bunishmans? | edical Examiner | disease of condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | S c | Due to (or as a | consequence of): consequence of): consequence of): | BSCESS | | | | Morth |
| ath ce | Physician/Mec | | L a | | | | | | | |
| the d | ysi | Part Ii. Other significant conditi | ons contributing to deat | h but not resulting i | n the underlying cause | given In Part I. | 23b. Did to | bacco use conf | tribute to t | the cause of deeth' |
| ras that the designed by the | | MENINGIOMA | OF BRA | łIN | | | 1 🗆 Y | es 2 No | 3 Probe | bly 40 Unknow |
| iaw requiras that the es been signed by th a 2 should be detache | Completed by | DIABETES | MILLION | | | | 24a. Was a perform | | com | e autopsy findings lable prior to pletion of cause eath? |
| The law ata hes paga 2 | E | CAMATRIC | | | | | 1 U Y | es No | | |
| certificat | | 25. Was case referred to medical | | | | 00 Plans (Day | | | 1 🗆 | Yes No |
| | S Be | examiner? | Managari e | | | Other | th (Check only on | | | |
| ding Phys h. Aftar this funeral di | ion: To | 27. Manner of Death 10€Natural 5 ☐ Pendi | 28a. Date of (Month, igation | Injury 28b. | Time of Injury 28c. In | 4 LI Nursing no | ome 5 ☐ Reside 28d. Describe ho | | | |
| To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afta completaly filled in by the fune | Certification: | 2 Accident Invest 3 Suicide 6 Could 4 Homloide determ | not be 28e. Place of | Injury - At home, fa , etc. (Specify) | arm, street, factory, office | | 28f. Location (St City or Town | | r or Rural i | Route Number, |
| Hospi 24 hou Funer staly fill | edicai | 29a. Certifier 1 Certifyi (Check only one) 2 Medical | ng Physicien: To the be Examiner: On the basi and manner | s of examination ar | e, death occurred at the nd/or investigation, in my | time, date and place, opinion, death occur | and due to the cared at the time, d | ause(s) and man ate and place, ar | ner as sta nd due to t | ted. he cause(s) |
| To the within 2 To the comple | ¥ | 29b. Signature and title of certific | 10000000 | | 29c. Lice | nse number | 2 | 9d. Date signed | (Month, D | ay, Year) |
| 0 | | 0m / | MD. | | | | | | | |
| ~ | - | | | | | 35941 | 1 | AUGUST | 20, | 1997 |
| | | 30. Name and address of person | R # 401 | 50 W. | EDMONGON | DR . ROU | | | | |
| Stat Registra | e . Ir | 31. Date filed (Month, AUG | 5 1997 32. Reg | is Paris Signature funa Davids | on-Randelle | | 1 | | | |



State of Maryland / Department of Health and Mental Hygiene 97 27 | 2

| | | | | | | Cer | tificate | of | Death | | Reg. N | No. | | | – |
|-----------------------|---|---------------|---|--|---------------------------------|---------------------|-----------------------------|---------------|---|------------------------------------|---------------|----------------|--------------------------|------------------------|------------------------|
| | | | 1. Decedent's Neme (First, Middle, La | ist) | | | | | | 2. Dete of De | eth | | V | 3. Tin | na of Deeth |
| | Physic /Medi | | Ida Mari | e Andrews | | | | | | Month August | 22 | , 199 | Yeer 97 | 2:3 | 30 A.M. |
| | Exami | | 4e. Fecllity Neme (If not institution, give | re street end number) | | | | | 4b. City, Town, or I | | | c. County | | | |
| | | | Manor Ca | re-Bethesd | a | | | | Bethesda | | | Moi | ntgom | ery | |
| Т | Funeral | | | | e (In yrs. lest bi | thday) | If Under 1 | | If Under 24 Hrs. | 8. Date of Bir (Month, Da | th | | | | tete or Foreign |
| L | Director | | 578-05-8635 Usual Residence of Decedent | I□M 2X0F | 84 | Yrs. | Months | Deys | Hours Min. | Oct. 1 | 0, | 1912 | Wash | ingt | on,D.C |
| | how | | 10e. Stete 10b. County | | 10c. City, Tow | n or Lo | cation | | | | | | 1 | 0d. Insid | de City Limits |
| | Partition | Director | Maryland Montgom | ery | Bethe | sda | | | | | | | | 10 | Yes 2 No |
| | or 2 | Pie | 10e, Street end Number | | | | 10f. Zip C | ode | | | 10g. C | Citizen of 1 | What Cour | ntry? | |
| | ath w | Funeral | 4761 Bradley Bou | | | | 208 | | | | | Unite | ed St | ates | } |
| | er de | une | 11. Maritel Stetus | 12. Wes Decedent E Armed Forces? | | 13. V | Ves Deceder Yes, specify | t of H | lispenic Origin? (S en, Mexican, Puert | pecify Yes or No o Rican, etc.) |) | | e - Americ ck, White, | | in, |
| 070 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show says figury or other traumatic svent, tra Medical Examiner must be notified at 2008. | by | 1 ☐ Never Merried 2 🕅 Merried 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☐ XN If Yes, Give Year or Dates: | lo | 1 | ☐ Yes 2☐ | χNο | Specify: | | | Specify | w: Wh | ite | |
| Mai yiaiin 21213-0020 | 72 h | Completed | 15. Decedent's E | ducation ade completed) | 16e | Deced | ent's Usuel (| occup done | etion during most of wor | kina | 16b. | Kind of B | usiness/în | dustry | |
| 7 | na. | Jd m | Etementary/Secondary (0-12) | College (1-4or 5 | +) | | | | during most of wor | AMI 9 | | | | | |
| 7 | her ti | | t7. Father's Neme (First, Middle, Last | 2 | | 1 | Homema | ker | | (First 18:44) | 14-7-4 | | Home | | |
| | ntai h | Be | | , | | | | | 18. Mother's Nan | | , Maide | en Sumen | 10) | | |
| 2 | d Me d Me mark | P | Logan Presler 19a. Informent's Name/Reletionship (| Time (Brint) | 100 | Mailia | . Add // | | Mertie end Numberor Ru | | . 01 | | 0: 4 = | | |
| > | d2s th an 7 is trau | | Peter P. Andrews | | | | | | Boulevard | | | | | | 1015 |
| Ď | Heal Heal Britisher | | 20e. Method of Disposition | ilasballa | 20b. Plece o | Dispos | sition (Neme | of L | Aug. 26 | Dete | | | City or To | | |
| Daithiole, | mant of mant of mant: If it | | 1 ☐ Bunal 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specific | | Montg | omer | cy Crei | nat | orium, I | nc. | Bet | hesda | a, Ma | ryla | ind |
| 0 | Departiment important in suny | | 21. Signeture of Funerel Service Licer | 1500 W-112 | _ M00348 | Bet | Name end / | -Ch | ss of FecilityRob revy Chas | ert A. | Pum 7 | phrey 557 V | Fun Visco | eral nsin | Home/ Ave., |
| | | | 23a. Pert1. Enter the diseese, or com shock, or heert feilure. List only | plicetions thet caused | | | | | faryland | | | | | Approx | Imate |
| | Physician | 2.1 | shock, or heart feilure. List only | one cause on each lin | е. | | | | | | | | | Interval | l Between end Deeth |
| | /Medical | | Immediate Ceuse (Finel disease or condition | Atheros | eleroti. | c Ca | rdiov | 200 | ular Dis | 0250 | | | į | l Ye | |
| | Examiner | | resulting In death) | 0 | Due to (or as e | - | | asc | ulai Dis | ease | | | | 1 16 | aı |
| - | D = | ner | | Type 1 1 | | , | | S | | | | | 1 | 10 Y | ears |
| | eath certificate be executed attending physician and for use as the burial-transit | Examiner | Sequentielly list conditions, | 0 | Due to (or es e | | - | | | | | | | | Jazo |
| 00100 | cian a | E | Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury | 6 | | | | | | | | | | | |
| 5 | cate chysi | edical | thet Initieted events resulting In death) Lest | | Due to (or es e | consequ | ience of): | | | | | | | | |
| | ding | Me | | d | | | | | | | | | | | |
| | atten for us | ian | | | | | | | | | | | | | |
| ; | be de | Physician | Pert II. Other significent conditions of | ontributing to death bu | t not resulting in | n the un | derlying cau: | se giv | en in Pert I. | 23b. Dld | tobacc | o use co | ntribute to | | use of death? |
| - | requiras that the death ce been signed by the attend should be detached for us | | | | | | | | | 1 🗆 | Yes | 2□ No | 3 Pro | bably | 4 Unknown |
| 5 | 8 64 | d by | | | | | | | | 24e. Wes | en eut | onev | 24h W | ere eutoi | psy findings |
| מכסומ | - W (7) | Completed | | | | | | | | | rmed? | | ev | elleble pi mpletion | rior to |
| 2 | has has | d L | | | | | | | | | | M | | death? | _V |
| | iclan: The certificata rector, pag | | OF Man ages referred to medical | | | | | | | 10 | | 2 1 No | 1[| Yes | 2[ANO |
| | | o Be | 25. Was case referred to medical exeminer? | Hospitel: | | | | Oth | er: . X | | - | | | | |
| 5 | Phys rthis aral d | 1. To | 27. Manner of Death | 1 ☐ Inpatier | | tpatient Time of | | | 4 E3 Nursing H | ome 5 Resident | | | | Y) | |
| 5 | ding Phy th. : Aftar thi s funeral | lg l | 12 Naturel 5 ☐ Pending 2 ☐ Accident Investigation | (Month, Dey | | njury | М | Injur Wor | k? Yes 2 □ No | | | , , , , , , | | | |
| | or Attending after death. Director: Attar I in by the fune | ertification: | 3 Suicide 6 Could not b 4 Homicide determined | 28e. Plece of Inju building, etc | ry - At home, fa . (Specify) | rm, stre | et, factory, o | ffice | | 28f. Location (: City or Ton | Street o | end Numb | er or Aura | Il Route I | Number, |
| • | To the Hospital or A within 24 hours after To the Funeral Directompletaly filled in by | edical Ce | 29a. Certifier Check only 2 Medical Exam | yalcian: To the best of | f my knowledge | , deeth | occurred et t | he tin | ne, date end plece | , end due to the | ceuse(| (s) end me | enner es s | teted. | |
| | the H nin 24 the F | | one) | niner: On the basis of end manner ster | ted. | WUT INV | eatigetion, in | шу о | prinon, death occu | ned et the time, | 1919 9 | na piece, | ena aue to | trie ceu | 58(5) |
| | | Σ | 29b. Signeture end title of certifier | 5/ | | | 29c. L | | e number | | 29d. D | ate signe | d (Month, | Dey, Yes | ar) |
| | 12 | | Muder | Cu- | _ | | | D5 | 120 | | Aug | ust 2 | 22, 1 | 997 | |
| | | | 30. Name end eddress of person who | completed cause of de | eth (Item 23e) | Type, F | Print) | | | | | | | - | |
| | | | Michael Emmer, M. | | | | Lvd., | Bet | hesda, M | D 2081 | 7-1 | 664 | | | |
| | Sta | ite | 31. Dete filed (Month, AUG 2 6 | 1997 32. Registra | ra Signature | A | andelle | | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene

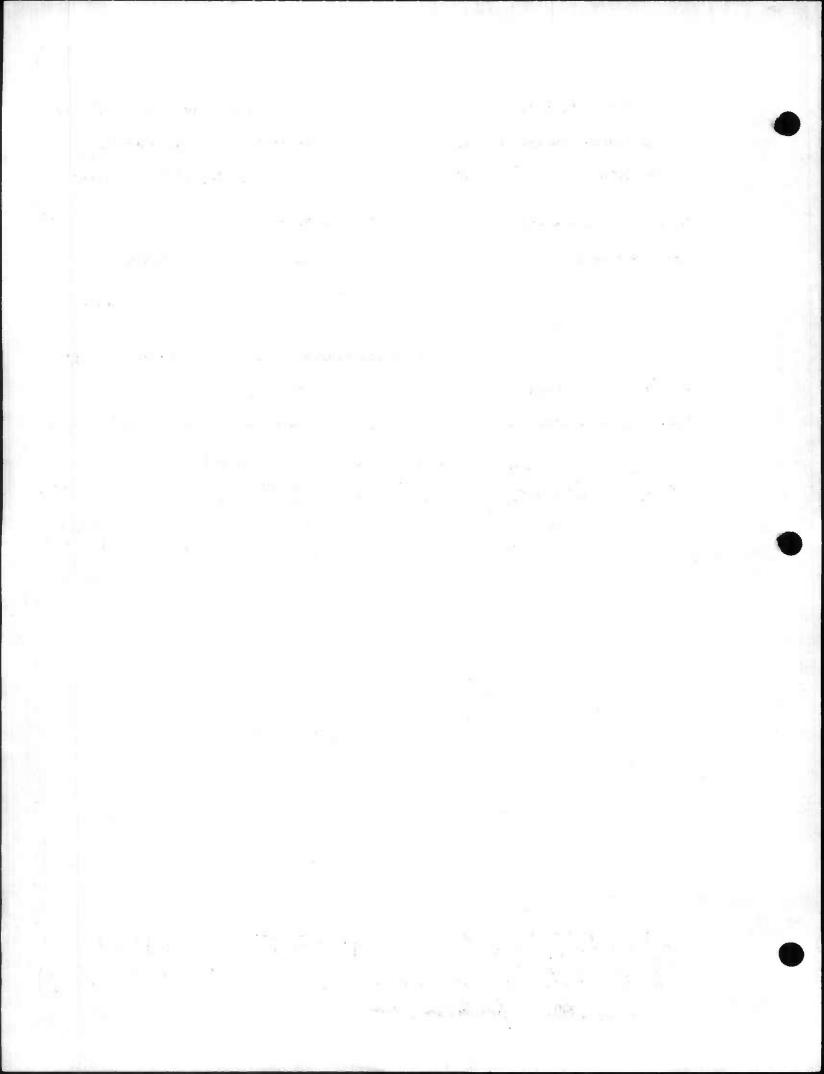
| | | | Decedent's Nema (First, Middle, L | | | | | | Death | 2. Data of D | Reg. No. | 1 2 | 3. Time of Death |
|----------------|--|----------------|--|--|------------------------------|--|-----------------------|------------------|--|-------------------------------|-------------------------------|----------------------------|--|
| п | Physic | | AGNES | OLIVIA | | | Dog | 3.75 | | Month | Dey | Yaar | |
| a | /Medi | | 4e. Facility Nama (If not institution, g | |) | | BOS | AK | 4b. City, Town, or | AUGUST | 16 , 19 h 4c. Count | | 8:15 P.M. |
| 1 | Exami | ner | 4202 SPRING AVEN | and the second second | | | | | HALETH | | BALTI | | |
| | Funeral Director | Г | | Sex 7. A 1 □ M 2 □XF | ga (In yrs. 76 | last birthday Yrs. | /) If Under Months | r 1 Yaar Days | | | | 9. Birthp Coun BALTI | lace (Stete or Foreign try) MORE |
| Π | pur * | | Usual Rasidance of Decedant 10e. Stata 10b. County | | 10c Cit | y, Town or L | ocation | | | | | 4 | 0d. Inside City Limits |
| | the Marylar 28a-f show notified at | 20 | 9 | BALTIMORE | 100. 01. | ,, | HALE | יחיוי | DF | | | | 1 ☐ Yes 2 No |
| | 28a | Director | 10e. Street and Number | DIMETRIONE | | | | p Code | CPE | | 10g. Citizen of | What Coun | trv? |
| | th with 23a or | <u>=</u> | 4202 SPRING AVEN | UE | | | 2 | 1227 | 7 | | | U.S.A | |
| | ter deat | Funeral | 11. Meritei Stetus | 12. Wes Decedant Armed Forces | Ever in U, | S. 13. | . Wes Dece | edent of | Hispanic Origin? (S en, Maxican, Puer | Specify Yas or No |)- 14. Rec | e - Americ | an Indian, |
| 21215-0020 | # PE | by | 1 ☐ Never Married 2 ☐ Married 3 💆 Widowed 4 ☐ Divorced | 1 Yas 21 if Yas, Give Yeer or Datas: | | | 1 Yas | | | (O NICET, VIC.) | Specif | ck, Whita, v | ITE |
| 5-0 | n 72 hours "natural". | Completed | 15. Decedant's E (Specify only highest g | ducation rada completad) | | 16a. Dece | edant's Usi | uei Occu | pation during most of wo | rkina | 16b. Kind of B | usinass/inc | lustry |
| 121 | nen nen | de la | Elemantary/Secondary (0-12) | Coilege (1-4or | 5+) | lifa. | DO NOT | use retire | ed) | | | | |
| | hygie her ti nt, th | | 8 17. Father's Name (First, Middle, Las | N/A | | SEC | RETAR | Y/CC | | ma (First, Middle | INSUR | | VFW |
| Maryland | 2 should be filed withle end Mental Hygiene. Is marked other than raumatic event, the M | Be C | CHARLES | VON B | ERGEN | 1 | | | ELLA | ma (rirst, Middle | | | TTAND |
| ary. | Shoul od Me mark | 2 | 19a. Informant's Neme/Raiationship | | DICOLIN | _ | ling Addres | s (Stree | t and Number or R | ural Route Numi | | | Code) |
| | nd 2 aith a 27 is r trac | | | DAUGHTER) | | | | | ASCOM CO | | | | |
| Baltimore, | tem Hem othe | | 20a. Mathod of Disposition | • | 0 | iace of Disp emetary, cre | osition (Na | ma of | | Data Data | 20c. Location | | |
| m E | Page net cont. If int: If | | 1 ☐ Burlal 2 【② Crametion 3 L 4 ☐ Qonation 5 ☐ Othar (Spec | | 1 | | | | ORY, INC | | DEL MCV | TTTE | MD |
| a | permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other trenscens. | | 21. Signature of Funeral Service Lice | nsee | City | 2 | 22. Nama e | nd Addr | ess of Fecility SI | NGLETON | BELTSV | HOME, | MD. |
| œ | 88 3 2 8 | | bull & | Lande | | 1 | SECO | ND A | VENUE, S | .W, GLEN | BURNIE | , MD. | 21061 |
| | Physician | | Part I. Enter the disease, or cor shook, or heart failure. List only | nplicetions that cause ona causa on each i | d the deeth | | | | | | | | Approximata interval Between Onset and Death |
| di. | /Medical | | Immediata Ceusa (Final | | | batic | 1 | | ance | | | į | 5 mus. |
| (A | Examiner | | rasulting in daath) | a. IY | | res a consa | aguance of | 9 | ancer | | | <u> </u> | |
| | P 품 | iner | | b | | | | | | | | 1 | |
| | tificate be executed g physician and as the buriel-transit | Examiner | Sequentially list conditions, if any leading to immediate | D | Dua to (or | r as a conse | equence of | : | | | | | |
| 68760, | be ay | | Sequentially list conditions, if any, leeding to immadiata cause. Enter Undarlying Cause (Disaase or injury | C | | | | | | | | | |
| 687 | ficata phys s the | edical | that initiated evants rasuiting in death) Last | | Dua to (or | as a conse | quance of) | • | | | | i | |
| Вох | attending for use a | | | d | | | | | | | | | |
| | death e atte d for | Physician/N | Part il. Other eignificant conditione | contributing to death t | out not rasi | iting In the | underlying | causa di | van in Part i | 23h Did | tahacco usa co | ntribute to | the cause of death? |
| <u>Р</u> | res thet the de igned by the a be detached | hys | The state of the s | John Dating to douth t | out not rust | nting in that | or darry mg | oausa gi | vair ii r git i. | 2 | Yes 2□ No | | ably 4 Unknown |
| | gned be de | by F | | | | | | | | | | | |
| Vital Records, | lew requires that the death cer es been signed by the attendin s 2 should be detached for use | ted | | | | | | | | 24a. Was | an autopsy | ava | ra autopsy findings |
| ecc | hes be | Completed | | | | | | | | | , | of c | npletion of causa leath? |
| <u> </u> | The eta h | Con | | | | | | | | 10 | Yas 2 No | 10 | Yas 2010 |
| Vita | Physician: The this certificata ral director, pag | Be | 25. Was casa raferred to medical axaminer? | 11 | | | | | | eth (Check only | ona) | | |
| 5 | this aldi | 2 | 1 Yas 2 No | Hospitel: 1 inpati | | ER/Outpatie | | UA | | Ioma 5 Anas | | |) |
| L | The state of the s | lon | 27. Manner of Deeth 1 ☑ Natural 5 ☐ Panding | 28a. Data of inju (Month, Da | ily Year) | 28b. Tima o injury | of M | 28c. inju Wo | ryat rk? Yas 2 □ No | 28d. Dascribe | how injury occur | red | |
| Division | deat ctor: y the | Certification: | 2 Accident Invastigation 3 Suicida 6 Could not to 4 Homicida | 00 - 01 | jury - At ho tc. (Spacify | me, ferm, st | | | 1145 2 110 | 28f. Location (City or To | Street and Numb wn, Stata) | er or Rura | Routa Number, |
| _ | To the Hospital or A within 24 hours effar To the Funeral Dire completely filled in b | edical Ce | 29e. Certifiar Certifying Pi | nysician: To the best minar: On the basis o | of my knov | vledge, deet | th occurred | at the ti | ma, deta and piece | e, end due to tha | ceusa(s) and ma | anner as st | eted. |
| | the Phin 24 the F | Medi | one) | end mannar st | etad. | .c.r sand/or II | | | | ou or me mild, | | | |
| | 6 | - | 29b. Signatura and titla of certifiar | | | | 29 | | sa number | | 29d. Data signe | a (Month, l | Jay, Year) |
| | | | Ju Oth | | N | | | 140 | 0850 | | Anjust | 18, | 1997 |
| ż | | | 30. Name and address of person who | | | - | | | WE BI | A | | | |
| | | | 31. Date filed (Month, Day, Year) | J. AND M. 32. Registr | | 700 | CAIS | YV A | 10 L) | TUIMO | LE WIT | | / |
| | Sta Registr | | Alic 1 0 100 | | o o o | 30 | . 145 | | | | | | |

DHMH 16 Rav 6/95

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| | | St | ate of Marylar | | artment of | | nd Mental H | | 7 27114 |
|---|------------------------------------|---|---|------------------------|---|-------------------------|--|------------------------|---|
| | | 1. Decedent's Name (First, Middle, Last) | | | innouto or | Doutt | 2. Date of D | Reg. No. | 3. Time of Death |
| Physic | | Nevada C. Bea | 11 | | | | Month | Day | Year |
| /Medi | | 4a. Facility Neme (If not institution, give street | | | | 4b. City. Tow | August vn. or Location of Dea | | |
| Exami | ner | Anne Arundel Medica | | | | | | | |
| Funeral | | 5. Sociel Security Number 6. Sex | 7. Age (In yrs. | lest birthdev) | If Under 1 Yea | | polis 4 Hrs. 8. Date of B | | rundel |
| Funeral Director | | 212-05-0406 | | Yrs. | Months Days | | Min. (Month, L | Dey, Year) | Birthplace (State or Foreign Country) |
| | | Usual Residence of Decedent | | | | | May 14 | , 190/ | Maryland |
| how | | 10a. State 10b. County | 10c. Ci | ty, Town or Lo | ocation | | | | 10d. Inside City Limits |
| Ma Interest | ctor | Maryland Anne Arund | ie1 | | Severr | na Park | | | 1 ☐ Yes XXNo |
| th th | Director | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen of W | hat Country? |
| 23a | | 161 Boone Trail | | | 2 | 21146 | | U.S. | Α. |
| r dea | Funeral | 11. Marital Status 12. W | es Decedent Ever In U | J,S. 13.1 | Was Decedent of | Hispenic Orlg | in? (Specify Yes or N Puerto Rican, etc.) | | - American Indian, c, White, etc. |
| or th | | 1 Never Married 2 Married 1 | ☐ Yes 2【 No Yes, Give | | 1□Yes 2XXV | | , | Specify: | , wille, etc. |
| 21215-0020 d within 72 hours after death with the Maryland piene. If than "natural", or items 23a or 28a-f show the Madical Erani or that the Invitred at | d by | | ear or Detes: | | | | | | White |
| 72 nat | Completed | 15. Decedent's Education (Specify only highest grade com | pleted) | 18a. Deced | dent's Usual Occu kind of work done DO NOT use retire | petion e during most | of working | 16b. Kind of Bus | siness/Industry |
| with a second | E C | Elementery/Secondery (0-12) C-12+ | ollege (1-4or 5+) | | | | | m | |
| N DOF | | 17. Fether's Name (First, Middle, Last) | | or/Mana | ger 's Name <i>(First, Midd</i> i | | ne Industry | | |
| Maryland d2 should be file in end Mental Hy 7 is marked oth traumatic evant | o Be | Warren Collins Brown | | | | | | | , |
| farylan 2 should be end Mental is marked aumatic ev | 2 | 19a. Informant's Neme/Relationship (Type, Pr | rint) | | Z Kirkwoo | | State Zin Code) | | |
| E - N . | | Mrs. Carole B. Schwar | | | | | | | |
| O - 1 2 5 | | 20a. Method of Disposition | | | DETVE ALT | 20c. Location - (| Ch, FL 32233. City or Town, State | | |
| 0 00 | | 1 ☐ Burial 2 【XCremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify) | al from State | | netory or other planetory | | 8-15-97 | | |
| Baltim permit. Pag Department Important: It any inlury o | | 21. Signature of uneral Service Dicenses |) " | 7 | . Name end Addr | | | Dailim | ore, Maryland |
| Ball permit | | A Source CVV | Κ., | В | arranco | & Sons | PA Severr | | uneral Home |
| - | | Ea. Part 1 Enter the discharge or complement | Live Salado Pro Carlo | Do not ent | 95 Ritch | ie Hwy | . Severna ardiac or respiratory | Park, MD | |
| Physician | 1 | 2a Part Linter the discher, or comp carbon shock, or heart failure. List only one car | se on each line. | | | | ar arabinatory | | Approximate Intervel Between Onset and Death |
| /Medical | 1 (| Immediate Cause (Final | Conges | Tive | Ha | Tra | Fail | 150 | MonTh |
| Examiner | ` | resulting in death) a. | | or es a consec | | NI 1 | 7 -111 | | MONIN |
| | ne | | 0001010 | JI 03 & COI1304 | delice oi). | | | | |
| 8760, ste be executed hysician end the burial-transit | Examiner | Sequentially list conditions. | Due to (c | or as a conseq | uence of): | | | | |
| 760, e be exe siclan e e burial-l | Ē | Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying | | | | | | | |
| 876 ete b hysic the br | dicai | Cause (Disease or Injury that Initiated events resulting In death) Lest | Due to (o | r as e conseq | uenca of): | | | | |
| A 6 | Mec | | | | | | | | |
| BOX 68 leath certificel attending phy of or use as the | an | d | | | | | | | |
| I HECOTGS, P.O. BOX 68 The law requires that the death certifice the hes been signed by the attending propage 2 should be detached for use as the contract of | Physician/Me | Part II. Other significant conditions contributi | ng to death but not res | ulting in the ur | nderlying cause g | iven In Part I. | 23b. Die | l tobacco use con | tribute to the cause of death? |
| res that the designed by the a | | Kenal Insu | Aficien | 101 | | | 10 | Yes 2 No | 3 Probably 4 Unknown |
| ecords, law requires ti es been signe 2 should be o | l by | 7 | 2 1 7 | v) | | 13 | | | |
| COrd require been signaled to | Completed | Mype 2 | Dinher | 15 | Melli | 1/05 | | s en autopsy ormed? | 24b. Were autopsy findings available prior to completion of cause |
| The law ate hes the page 2 s | idm | 3) (| | | | | | | of death? |
| | | | | | | | 1□ | Yes 20 No | 1 ☐ Yes 2 ☐ No |
| Of Vital Physician: The this certificate ral director, pag | Be | 25. Was case referred to medical examiner? | | | | | of Deeth (Check only | one) | |
| Of thys | . To | TE Tes 2EMO | 1 ☐ Thpatient 2 ☐ | ER/Outpatien | T 3LI DOA | | sing Home 5 Res | | |
| Jing I | lo lo | 1 ☐Natural 5 ☐ Pending | i. Date of Injury (Month, Dey Year) | 28b. Time of Injury | | ork?]Yes 2 □ N | | how injury occurre | d |
| Attending or deeth. | ical | 2 Accident Investigation 3 Sulcide 6 Could not be | e. Place of Injury - At he | ama farm etr | | | | (Street and Numbe | r or Rural Route Number, |
| INISION Tor Attending after deeth. Director: After din by the fune | Certification: | 4 ☐ Homicide determined 256 | building, etc. (Specif | y) | set, factory, office | ' | City or To | wn, Stete) | r or Hurar House Number, |
| spital ours ersi | | 29a. Certifier Certifying Phyalcian: | To the hest of my kno | wledge death | occurred at the t | ime date and | place and due to the | causa(s) and man | unor ac etatod |
| UIVISION To the Hospital or Attending 6 within 24 hours after deeth. To the Funeral Director: After completely filled in by the funeral | edical | Check only 2 Medical Examiner: O | n the basis of examine nd manner stated. | tion and/or Inv | estigation, in my | opinion, death | occurred at the time | , date and place, a | nd due to the ceuse(s) |
| omp | Me | 29b. Signature end title of certifier | / | | 29c. Licen | se number | | 29d. Date signed | (Month, Dey, Year) |
| - > - 0 | | Dan (VIE | rent | | Dr | 796 | 5 | 8/15 | 197 |
| | | 30. Neg a and address of person who complete | od cause of deeth (Item | n 23a) (Type I | Print) | | 1 /- | -1-51 | |
| | | 205 Ridge | ly Ave | Bm | molis | , W | . (4 | dseih 1 | V. Friend |
| Sta | - 1 | 31. Date filed (Month, Dey, Year) | 32. Registrar's Signa | iture | | 1 | | 1 | |
| Registr | AUG 1 9 1997 Spile Deviden Mondale | | | | | | | | |

Registrar DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First Middle Lest) 2. Data of Deeth 3. Time of Death **Physician** Month Day Yaar William Edwin Blayton August 17, 1997 /Medical 6:40am 4a. Facility Nama (If not institution, giva street end numbar) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** 1055 Rustling Oak Drive Millersville Anne Arundel If Undar 1 Year If Undar 24 Hrs. 8. Data of Birth
Months Days Hours Min. May 2, 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Months 1 X M 2 □ F 228-40-2936 Yrs. 64 Director Virginia Usual Residence of Dacedent death with the Maryland 10a. Stata r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Insida City Limits MD Anne Arundel Funeral Director Millersville 1 Yas 2 NO 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 1055 Rustling Oak Drive 21108 USA 12. Was Decadant Evar in U,S. Armad Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Heelith and Mental Hygiene. Important: If item 27 is marked other than "natural, or ite any inJury or other traumatic event, the Modella Example any inJury or other traumatic event, the Modella Example. TYas 2 No f Yas, Giva 1/ 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: Korean 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Dacedant's Education (Spacify only highast grada completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Vice-President 12 Shipping 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be Newell Hause Blayton Tda Coleman 2 19a. Informant's Name/Ralationship (Typa, Print) 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Vivian Blayton/wife 1055 Rustling Oak Drive, Millersville, MD 20b. Place of Disposition (Nama of 20a. Mathod of Disposition Data 20c. Location - City or Town, State cematary, cramatory or other placa) Aug 21 1 Burial 2 Cramation 3 Ramoval from Stata Newport News. VA 4 ☐ Donation 5 ☐ Othar (Specify) Peninsula Memorial Park 1997 21. Signature of Funaral Sarvice Licansee 22. Nama and Addrass of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between **Physician** Wastoma Will forme /Medical Immediata Causa (Final disaesa or condition rasulting in deeth) Examiner Physician/Medical Examiner The law requires that the death certificate be axecuted for use as the burial-tran Sequantially list conditions, if eny, leading to immadiata ceusa. Entar Undarlying Causa (Disaase or Injury that initiated ascents. Due to (or as a consequence of): P.O. Box 68760, that initiated evants rasulting in death) Last Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 3 Probably 4 Unknown No Division of Vital Records, þ 24b. Wara autopsy findings available prior to complation of causa of death? Be Completed 24a. Was an autopsy performed? peen this certificate has 1 ☐ Yas 2 No 1 TYas 2 No or Attending Physician: director 25. Was cesa referred to medical 26. Placa of Death (Check only one) axaminar 2 NO Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Daath 28a. Data of Injury (Month, Day Year) Certification: 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred Aftar t 1 Naturel 5 Panding Invastigation To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur death. 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datarmined 3 Sulcida 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

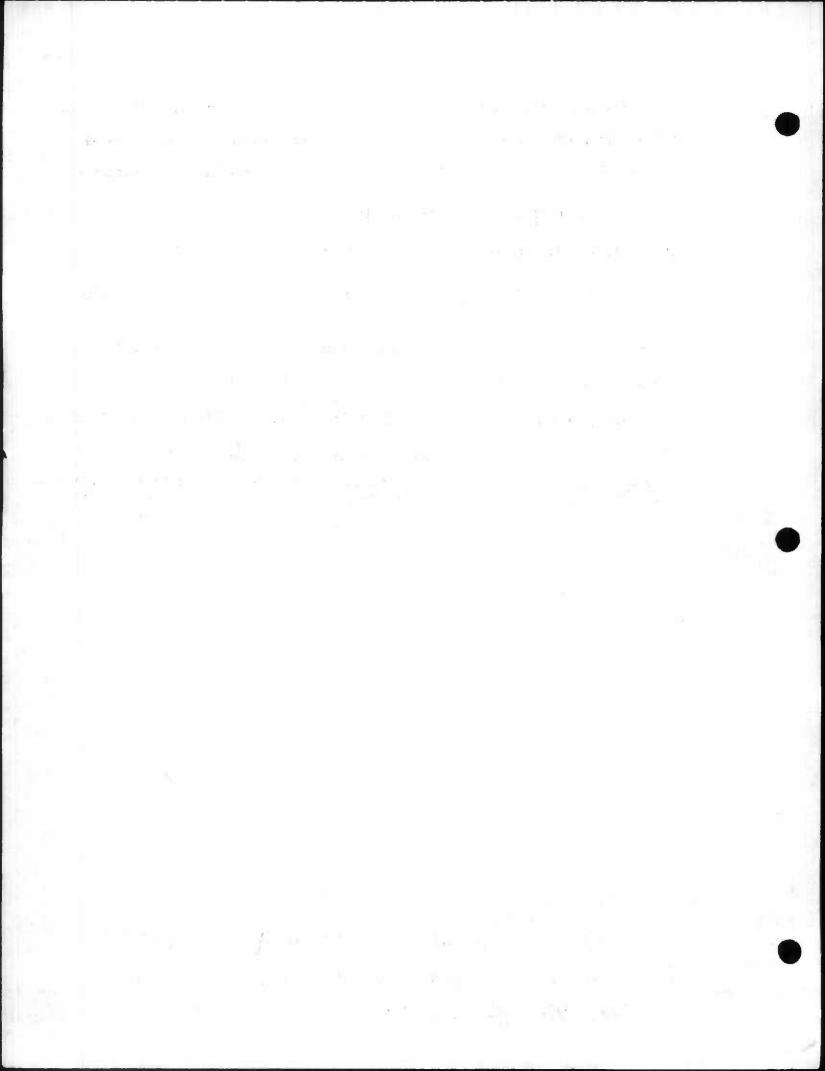
Certifying Physician: To the best of my knowledge, death occurred at the time, due to the cause(s) and manner as stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, due to the cause(s) and manner as stated. edical 29a. Cartifian (Check only onel 29b. Signature and title of 29d. Data signed Month, Day, Year) 30. Name end address of person who completed causa of th (Item 23e) (Type, Print) eter GRERE MD

Registrar

State

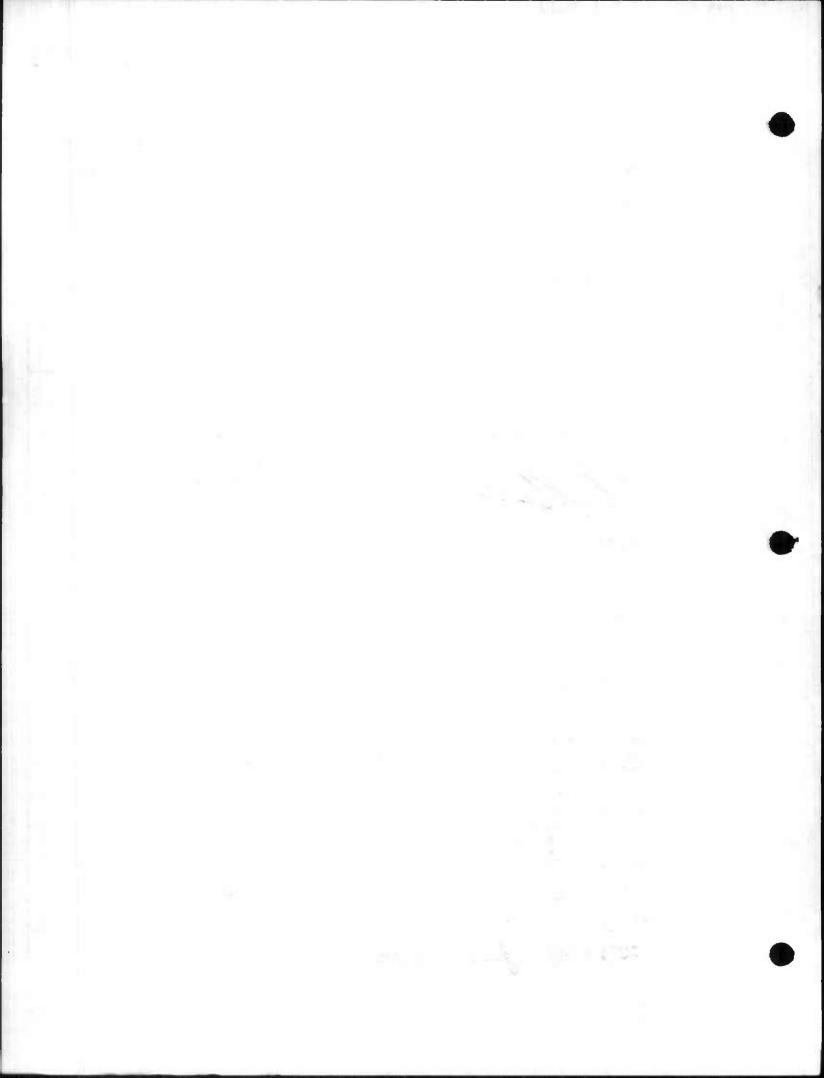
31. Data fillad (Month, Day, Year) AUG 1 9 1997 Bestgate
32. Registrar's Signatura



| HE HQSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | his certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | ted, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
|---|---|--|--|
| ITENDING PHYSICIAN: The law requires that the death certificate be | TOR: After this certificate has been signed by the attending physician | after death with the State Dept. of Health and Mental Hygiene prior 1 | 28 is marked, or item 23 shows any injury, or other trau |
| TO THE HOSPITAL OR AL | TO THE FUNERAL DIRECTOR: After the | be filed within 72 hours | IMPORTANT: If Item 28 is marked, |

31. DATE FILED (Month, Day, Year)
AUG 21 1997

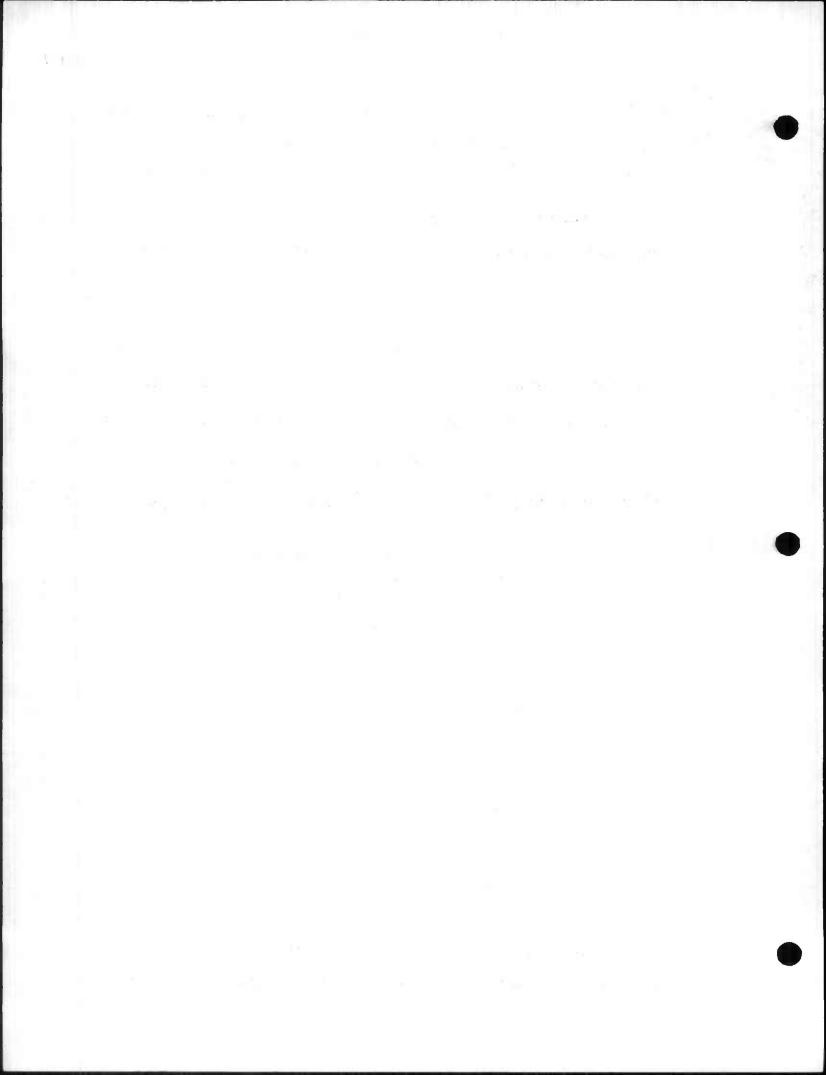
| | | | | | | - | | OF DEATH | | | 3. TIME OF DEATH |
|---|--|--|--|--|--|--|--------------|--------------------|--------------------------|-------|---|
| Jeanneti | te Ber | der | | | | | Augu | | 9 199 | EAR 7 | 9:55 AM |
| SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. | lest birthday) | IF UNDER 1 | | UNDER 24 HRS. | 7. DATE O | OF BIRTH | 8. | BIRTH | PLACE (State or Foreig |
| 110-26-1557 | 1 M 2 XF | 95 | YRS. | MONTHS | DAYS HO | URS MIN. | | 23 19 | | Nor | y York Cit |
| e. FACILITY NAME (If not institution, give street | et and number) | | | 9b. CITY, T | OWN OR LO | OCATION OF DI | | 47 17 | Sc. COUNTY | | |
| Annapolis Nursing | & Rehab | Cente | r | A | Annapa | olis | | | Anne | Ar | undel |
| RESIDENCE OF DECEDENT 10b. COUNTY | | | | , TOWN OR | | | | | | | 10d. INSIDE CITY |
| | Arundel | | 100.011 | | | .1 | | | | | LIMITS? |
| 00. STREET AND NUMBER | Ardidei | | | E. | nnapo | | | | 10g. CITIZEN | OF W | VHAT COUNTRY? |
| 224 Wardour Driv | 7 e | | | | | 2140 | 1 | | IIni t | . d | Chahas |
| | 12. WAS DECEDEN | T EVER IN U.S. | ARMED | | | ENT OF HISPAI | NIC ORIGIN | | | RACE | States - American Indian, |
| Never Married 2 Married | FORCES? 1 | YES 2 [| XNO | | yes, specify YES 2 | Cuben, Mexica XNO Specif | | tican, etc.) | | | white, etc. |
| Wildowed 4 Divorced | | | | | | 21 | | | | | MILLE |
| 15. DECEDENT'S EDUCA (Specify only highest grade co | | 16a. | Give kind of w | rork done du | CUPATION ring most of | working | 16b. | KIND OF BU | SINESS/INDUST | TRY | |
| Elementary/Secondary (0-12) | College (1-4 or 5 | •) | life. Do NOT us | 11000 | | | | | | | |
| 7. FATHER'S NAME (First, Middle, Last) | 2 | | Homem | aker | L | 1405115717 | | | Home | | |
| Julius Bender | | fiddle, Meiden | | | | | | | | | |
| JUIIUS DENGET 9a. INFORMANT'S NAME (Type/Print) | | 40 | 10h MAH INO | ADDDESS / | Otmat and 41 | | | Schw | artz m. Stata, Zio Co | rda) | |
| Joan Hochman (Da | | | | | | | | | | | |
| On. METHOD OF DISPOSITION | ugnter) | 20h Bi A | CEAND DATE | ardou | r Dr | ive Ai | nnapo | 118. | Marylan | nd_ | 21401 |
| XXBuriel 2 Cremation 3 Remov | al from State | or cemer | ary, Grennatury | or other plat | ce) | Cemete | | 99 70° E | Altimos | re. | Maryland |
| 23. PART I. Enter the diseases, or co shock, or heart failure. Li MMEDIATE CAUSE (Final disease or condition resulting in death) | mplications the | it caused the use on each I | death. Do n | ot anter th | he mode o | of dying, suc | ch aa card | llac or reap | Iratory arrest | ł, | Approximata interval Betw Onset and D |
| | DUE/10 | IODYNE A CON | | The state of the s | 114 | 2 | | | | | 14900/ |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | (OR AS A CON | | 7: | 190 | Quantum Control of the Control of th | | | | | 1 1000/ |
| If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa | DUE TO | (OR AS A CON | SEQUENCE OF | 7): | Age erlying ca | Question in | 1 Part I. | 24a. WAS AN PERFOI | RMED? | 24b | WERE AUTOPSY FINDS MAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? |
| of any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST | DUE TO | (OR AS A CON | SEQUENCE OF | 7): | Agranged and the series of the | Quese given in | 1 Part I. | PERFO | RMED? | 24b | WERE AUTOPSY FINDS MAILABLE PRIOR TO COMPLETION OF CAU |
| of any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa reaulting in death) LAST d. PART II. Other algnificant conditions S. WAS CASE REFERRED TO MEDICAL | DUE TO | (OR AS A CON | SEQUENCE OF | 7): | | Quese given in | | PERFOI | RMED? | 24b | WERE AUTOPSY FINDS MAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? |
| if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST d. PART II. Other algnificant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | DUE TO | (OR AS A CON | SEQUENCE OF | other: | 26. PLACE | OF DEATH (C) | heck only on | PERFOI | RMED? | 246 | WERE AUTOPSY FINDS MAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? |
| if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST d. PART II. Other algnificant conditions 85. WAS CASE REFERRED TO MEDICAL EXAMINER? | DUE TO | (OR AS A CON (OR AS A CON death but no | DEQUENCE OF | OTHER: | 26. PLACE ing Home 5 iBc. INJURY WORK? | OF DEATH (C) | heck only on | PERFOI 1 YES : | RMED? | | WERE AUTOPSY FINDS MAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? |
| if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST PART II. Other algnificant conditions IS. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO IV. MANNER OF DEATH 1 Netural 6 Pending | DUE TO contributing to HOSPITAL: 1 Inpetient 2 (| (OR AS A CON (OR AS A CON death but no | SEQUENCE OF DE POSITION DE LA SEQUENCE OF DESCRIPTIONE OF DE LA SEQUENCE OF DE LA SE | OTHER: | 26. PLACE ing Home 5 i | E OF DEATH (C) | heck only on | PERFOI 1 VES : | INJURY OCCUR | RED | WERE AUTOPSY FINDS MAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO |



State of Maryland / Department of Health and Mental Hygiene Q 7 27117

| | | | | , | Certi | ificate of | | ioniai riy | Reg. No. | 4 | |
|---|----------------|---|---|----------------------------|------------------------------|------------------------------------|---|--|---------------------------------------|-------------------------|---|
| Dhualaic | | 1. Decedent's Name (First, Middle, La | st) | | | | | 2. Date of De | | Yeer | 3. Time of Death |
| Physicia /Medic | | MARGARET | н. | | BAI | RWICK | | August | | | 10:15 PM |
| Examin | | 4a. Facility Name (If not institution, give | e street end number) | | | | 4b. City, Town, or Lo | | | | |
| | | Memorial Ho | | | | | Easton | | Tal | bot | |
| Funeral Director | | 214-46-4192 | D | 8 (In yrs. lest i | | If Under 1 Yee Months Day: | | 8. Date of Birt (Month, Date OCT - 1 | y. Year) 2,1908 | 9. Birthp Coun MA | olace (State or Foreign htry) RYLAND |
| pus * | | Usuel Residence of Decedent 10a. State 10b. County | | 10c. City, To | own or Local | tion | | | | 1 | 0d. Inside City Limits |
| f sho | ō | MD TALBO | ידי | | STON | | | | | | 1 ☐ Yes 2 ŽNo |
| 28a notifi | Director | 10e. Street end Number | | | | 10f. Zip Code | | | 10g. Citizen of W | hat Coun | nn/2 |
| 23a or | | 29080 COLLIE | RLANE | | | | 21601 | | USA | 10001 | |
| o. Page | by Funeral | 11. Maritel Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced | 12. Was Decedent E Armed Forces? 1 Yes 27 N If Yes, Give Year or Dates: | | | s Decedent of es, specify Cu | Hispanic Orlgin? (Spiban, Mexican, Puerto o Specify: | ecify Yes or No- Rican, etc.) | 14. Race Bleck Specify: | , White, | |
| 72 h | eted | 15. Decedent's Ed (Specify only highest gra | ducation | 16 | Sa. Deceden | nt's Usual Occi | upation e during most of work | ina | 16b. Kind of Bus | iness/Inc | dustry |
| Pan Pan | Completed | Elementary/Secondary (0-12) | Coilege (1-4or 5- | +) | | | e during most of work | 9 | GROC | FDV | |
| Paris A | ဝိ | 11 17. Father's Name (First, Middle, Last) | | | BOO | KKEEPI | | (Final 86) | | | |
| id be f ental h ked of | To Be | JOHN WINDER I | | 2. | | | 18. Mother's Name ANNIE | | BOOTH | " | |
| athou man | - | 19a. Informant's Name/Reletionship (| Type, Print) | 15 | 9b. Mailing | Address (Stree | et end Number or Run | al Route Numbe | er, City or Town, S | Stete, Zip | Code) |
| alfha 27 is r fra | | FAYE B. COLL | ER/DAUGH | TER | 2904 | 6 COL | LIER LANI | E, EAS | TON, MI | 21 | 601 |
| ages 1 a nit of He it if flem y or othy | | 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ | | ceme | tery, cremet | ion (Neme of tory or other pi | | Date | 20c. Location - C | | |
| ortan ortan | - | 4 □ Donation 5 □ Other (Specification 21. Signeture of Funerel Service Licer | | SPRIN | | | METERY 8 | 3-28 | EASTON, | MD | |
| Dept Impo | | M. E. News | HAMI TH | CF.SI | O FEL | LOWS, | HELFÉNBI | | | | ERAL HOME 21601 |
| | | 23a. Part1. Enter the disease, or com | plications that caused | the deeth. D | o not enter t | the mode of dy | ARRISON S | or respiretory er | rest, | MD | Approximete |
| Physician | | shock, or heart feilure. List only | One ceuse on each im | θ. , ê | / | , | - 4 | | | 1 | Interval Between Onset and Death |
| /Medical | | Immediate Cause (Final disease or condition | Com | No | e 1/6 | ent 1 | Poulars | | | | Zwah |
| Examiner | ē | resulting in death) | 0,0 | ue to (or as | a conseque | ince.of): | [.00 M. | 10.01 | e Infor | 4 | 2.100/ |
| cuted | Examiner | Sequentially list conditions. | b. 01111 | Due to (or as | a conseque | ince of): | Jack 10141 | CAMIL | 2 Crugwi | cian | - way |
| Du Cie | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | . ark | riosa | Peroto | i b | cash th | Slave | | | Yews |
| 100 PR 40 | edicai | that initiated events resulting in death) Last | | oue to (or es a | a consequer | nce of): | | | | i | |
| es ip | Z | | d | | | | | | | + | |
| deat de ett | Sicient | Pert II. Other significant conditions o | ontributing to death bu | t not resulting | g in the unde | erlying cause o | given In Part I. | 23b. Did 1 | tobecco uae cont | ribute to | the cause of death? |
| at the | Physician/M | Barto Ob | and dai | Duno | | , - | | 10 | Yes 2 No | 3 Prot | bably 4 Unknown |
| es the | þ | may 19 | me you | cury | | | | | т. | | |
| The law requires that the death cer ate has been signed by the ettendir page 2 should be deteched for use | Completed | | V | | | | | 24e. Was perfo | en eutopsy med? | eva | ere autopsy findings allabie prior to mpletion of cause death? |
| Physician: The law this certificate hes ral director, page 2 | EO | | | | | | | 101 | res 20 No | | ☐Yes 2☐No |
| In: T | BeC | 25. Was case referred to medicai | / | | | | 26. Place of Death | | 10 1200 | - 10 | 7103 20110 |
| ysicia s cer direc | 20 | exeminer? | Hospital: 1 Inpatier | nt 2 ER/ | Outpatient | 3 DOA | ther: | | dence 8 Othe | r (Specifi | v) |
| g Ph | | 27. Manner of Death | 28a. Date of fnjun (Month, Dey | | . Time of Injury | 28c. Inj W | | | now Injury occurre | | |
| ath. r: Aft | atio | 1 Natural 5 ☐ Pending investigation | | r our/ | irijary | | Yes 2 □ No | | | | 54. 4.5/69 |
| r Atte | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined | 28e. Place of Inju building, etc. | ry - At home, (Specify) | farm, street | t, fectory, office | Э | 28f. Location (S City or Tow | Street end Numbe | r or Rura | l Route Number, |
| rs eff | | | | (, | | | | | | | |
| | edical | 29a. Certifier (Check only one) 1 ☐ Certifying Ph | yaician: To the best of ninar: On the basis of and manner stat | examinetion a | ge, death or and/or inves | ccurred at the stigation, in my | time, date and place, opinion, death occurr | and due to the ed at the time, | cause(s) and man date and piece, a | ner as st nd due to | ated. the cause(s) |
| withir To th | M | 29b. Signeture and title of certifier | . / / | \cap | 1 ^ | | nse number | | 29d. Date signed | (Month, | Dey, Year) |
| | | ▶ Willeam | HWard | 1 | (71) | 100 | 08715 | | 8/26, | 187 | |
| | | 30. Neme and address of person who | | | | | יית אודע אודע | יים קון | CHOM | MD 1 | 26101 |
| | | WILLIAM H. WOO 31. Date filed (Month, Day, Year) | D, JR., I | | 206 | TOPEM | TID AVEN | UE, EA | STON, I | MD 2 | 26101 |
| Stat Registra | | AUG 2 6 | 32. Registra | | vidson | Pandell | | | | | |
| | | 700 20 | 1001 | 1 | | | | | | | |

Division of Vital Records, P.O. Box 68760,



Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Death Day **Physician** GLORIA BROWN August 19, 1997 /Medical 8:03Pm 4e. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth **Examiner** THE JOHNS HOPKINS HOSPITAL BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2√2F Director 54 Yes 219-54-4510 Sept. 15 1942 Usual Residenca of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits MD Frederick Frederick Director 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Cifizen of What Country? 2222 Broadway St. Apt. 2 21701 USA Funeral 12. Was Decadent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No þ Specify: black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Dacedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pernit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any Injury or other traumatic event. Elamantary/Secondary (0-12) Collage (1-4or 5+) 10 housekeeper Janitorial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Henry Lee 2 Margaret Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 25 Nunnery Lane Catonsville, Md. 21228 Grace Davis (neice) 20b. Placa of Disposition (Name of cametary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Othar (Specify) 8/23/97 Bushy Park Cemetery Cooksville, Md. 21. Signatura of Funeral Servica Licansee 22. Name end Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md. 21784 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. interval Between Onset and Death Physician /Medical Immediate Cause (Final LACTIC ACIDUSIC 24 HOURS disease or condition rasulting in death) Examiner 4 MONTHS PULMONIARY HYPERTENSION Sequentially list conditions, if any, leading to Immadiate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last Due to (or as e consaquence of) and P.O. Box 68760. physician DILATED CAROTOMYOPATHY YEAR Physician/Medicai the Due to (or as e consequence of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23b. Did tobacco use contribute to the cause of death? 1 Yes 2No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 Yes No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified completely filled in by the funeral director, 25. Was case referred to medical Be 28. Placa of Death (Check only ona) exeminer? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 70 27. Manner of Death 28d. Dascribe how injury occurred 28b. Time of 28c. Injury et Work? Medical Certification: 28a. Date of Injury (Month, Day Year) 1 Natural 5 Panding 1 Yes 2 No Investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida Certifying Physician: To the best of my knowledga, daath occurred at the tima, data and placa, and dua to tha cause(s) and manner as stated.

Medicat Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the tima, date and placa, and dua to tha causa(s) and mannar stated. 29a. Cartifiar 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 30. Name and addrass of person who complated cause of death (Item 23a) (Type, Print) FRED CHAN 600 NORTH WOLFE STREET BALTIMORE MARYLAND 21287-8/06

Registrar's Signature

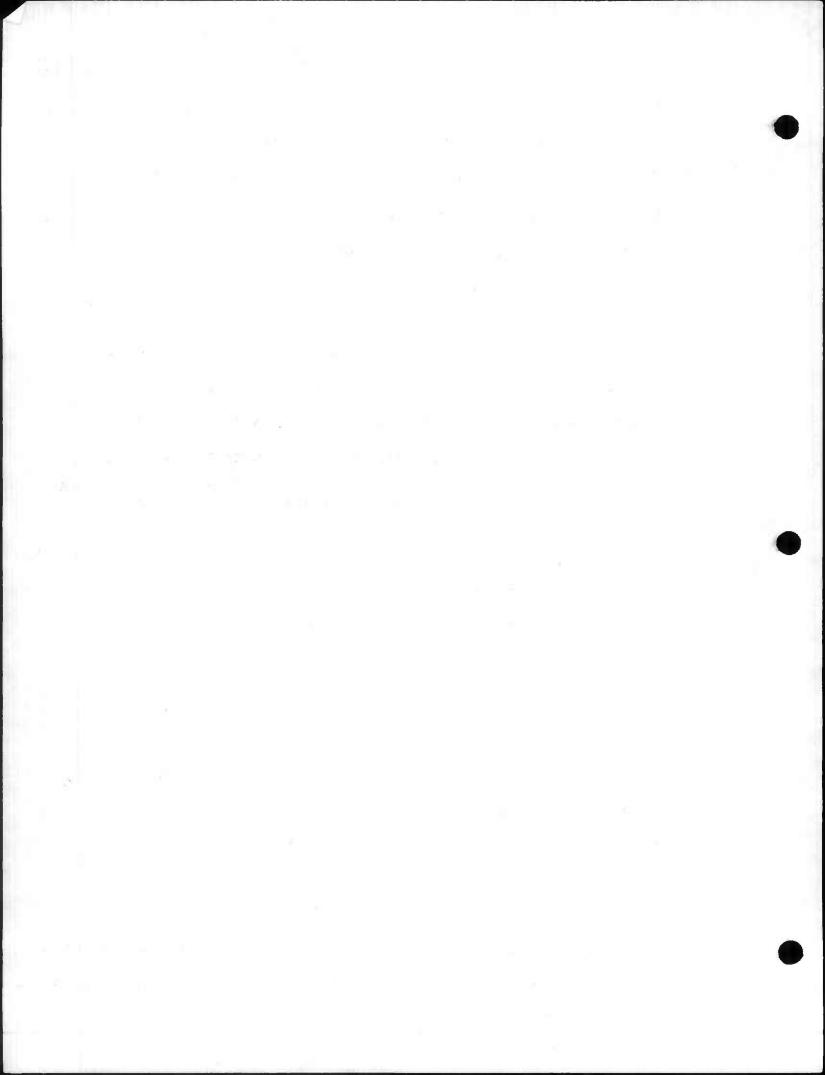
DHMH 16 Rev 6/95

State

Registrar

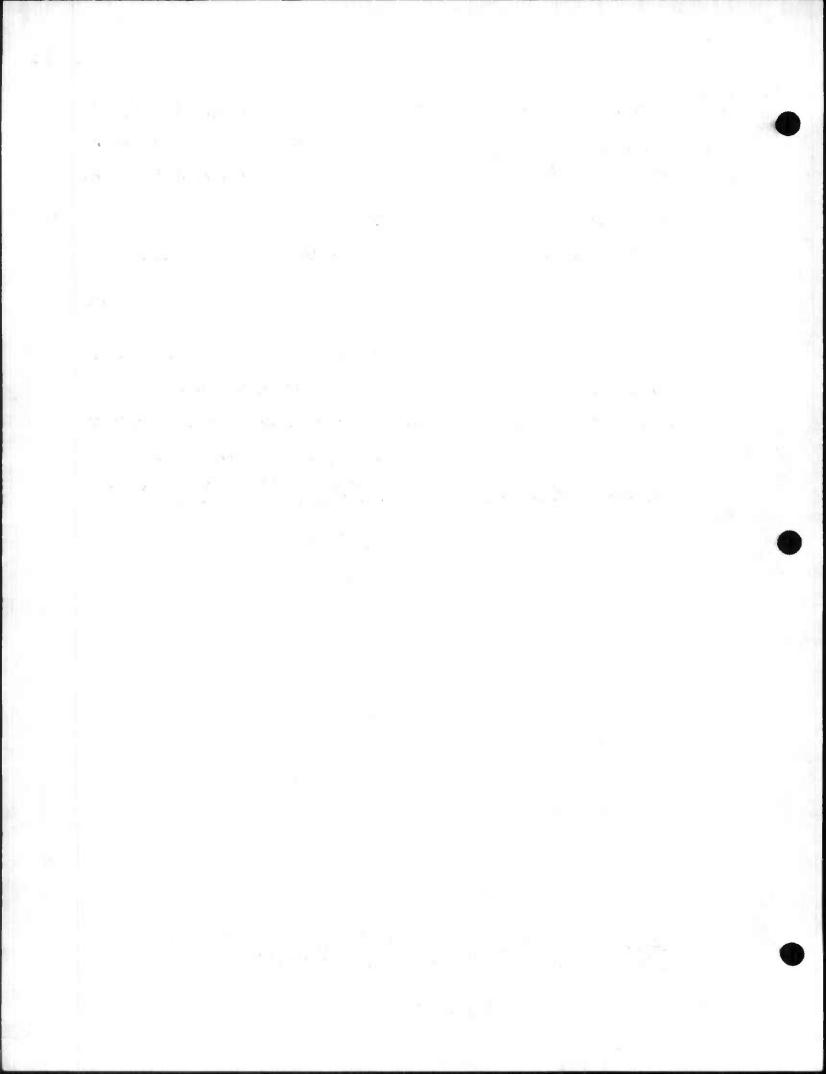
31. Date filed (Month, Day, Year)

AUG 2 5 1997



State of Maryland / Department of Health and Mental Hygiene 97 27 | 19

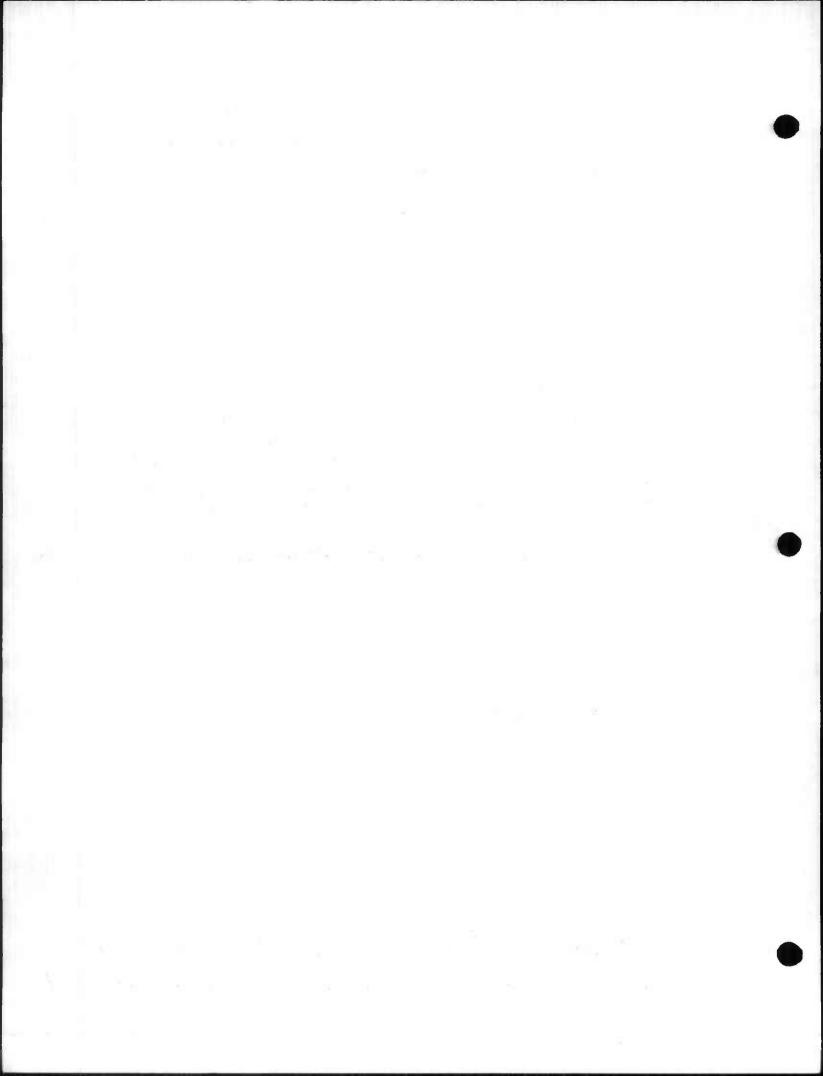
| | | | | | | Certificate o | f Death | | Re | eg. No. | | Lan 1 1 1 2 |
|----------------|--|------------------|---|---|--|--|----------------------------------|--------------------------|----------------------------------|------------------------------|--------------------------------|---|
| П | Discort. | | 1. Decedent's Nama (First, Middla, | Last) | | | | 2 | . Data of Deat | h | | 3. Tima of Death |
| J | Physic /Medi | | DAVID | JOHN | BAR | RY | | 1 | AUGUST | Dey | 1997 | 5102 nw |
| | Exami | | 4e. Facility Nama (If not institution, | | | | 4b. City, To | wn, or Loca | tion of Daath | 4c. Coun | ty of Deeth | o .oup. |
| 1 | | | Stella Maris H | neni ce | | | Tows | on | | Ba | ltimo | re |
| Т | Funeral | | 5. Social Security Number 6 | S. Sex 7. Age | e (In yrs. last birt | | er If Undar | | Data of Birth (Month, Day, | 4 | | place (Stete or Foraign |
| ŀ | Director | | 220-52-3404 Usuel Rasidanca of Decedent | X□M 2□F | 49 | rs. Months Day | s Hours | Min. | ec. 4, | 1947 | Mary | land |
| | and ** | | 10a. Stata 10b. County | | 10c. City, Town | or Location | | | | | 1 | 0d. Insida City Limits |
| | Aaryd Sho | ō | MD Harfo | | | | | | | | | 1 ☐ Yas 2 ☐ No |
| | the the | 2 | 10e. Straat and Numbar | Lu | rores | t Hill 10f. Zip Code | | | 4 | On Ohinan at | | Λ |
| | with a | Funeral Director | 2009 Highfield | Court | | | 21050 | | 10 | Og. Citizen of | | try? |
| | eath Fr | era | 11. Marital Status | 12. Was Dacedanf E | Ever in II S | | | nino (Canadi | h. Vaa as Na | U.S | | on Indian |
| | iter d | 5 | ty Naver Marriad 2 Married | Armed Forcas? | ADDITION OF THE PARTY OF THE PA | 13. Was Dacedant of If Yes, specify Cu | ban, Mexicen | , Puarto Rio | cen, etc.) | | ece - Amarica ack, Whita, e | |
| 020 | urs al | by | 3 Widowed 4 Divorced | If Yas, Giva Yaer or Datas: | .0 | 1□ Yas 21 N | o Specify: | | | Speci | ily: Whi | ite |
| 21215-0020 | within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show ha Modical Examinat Los notified at | Completed | 15. Decedant's (Specify only highast) | Education | 16a. | Decedant's Usual Occ (Giva kind of work don | upetion | a francisco | | 16b. Kind of | 3usinass/Inc | dustry |
| 121 | d within piene. r than " | mpie | Elamantary/Sacondary (0-12) | Collaga (1-4or 5- | +) | lifa. DO NOT usa retii | red) | or working | | | | |
| 12 | | | | 2 | | Machines | T | | | Steel | | try |
| Maryland | S is b | Be | 17. Fathar's Name (First, Middla, La | st) | | | 18. Mofhe | r's Nama (F | First, Middla, N | faidan Suma | me) | |
| Yes | should be and Mental marked o | 10 | David Barry | | | | | | h Jone | | | |
| Jar | 2 0 0 | | 19a. Informant's Name/Ralationship | | | Mailing Addrass (Strai | | | | | | |
| | C = N - | | Mr. Joseph Barry | y (Brother) | 1 | 25 Meadowy | view Dr | ive N | orrisv | ille, | MD 211 | 161 |
| 0 | 50 50 = 0 | | 20a. Mathod of Disposition 1 🛣 Burlal 2 ☐ Cramation 3 | ☐Removal from Stata | 20b. Place of cemetary | Disposition (Nama of r, crematory or othar pi | lece) | | Dete 2 | 20c. Location | - City or To | wn, Stata |
| Baltimore, | permit. Page Department of Important: If any Injury or soce. | | 4 ☐ Donation 5 ☐ Othar (Spec | | Wards | Chapel Cem | etery | 8/2 | 2/97 1 | Randal | lstown | a, MD |
| 3ali | Departiment mportunities in his in hi | | 21. Signature of Funaral Service Lic | ansee | | 22. Name and Add Haight F | rass of Facility | Home | & Char | nel (B | ov 191 | 5) |
| T. | 20559 | | buan . | Hught in | | Sykesvil | | | | | | , |
| | | | 23a. Part1. Entar tha disaasa, or co shock, or haart failura. List on | mplications that caused | tha daath. Do n | | | | | | | Approximata Interval Batwaan |
| V | Physician | | | , | | | | | | | | Onsat and Death |
| | /Medical | | Immediata Causa (Final disaasa or condition | . 6 | 127 | CINES | | 150 | | | | |
| П | Examiner | | rasulting in daath) | a1 | Dua to (or es e c | onsaquanca of): | | THE | 5 | | | |
| | V # | he | | | | | | | | | 1 | |
| | tflicate be executed g physician and es the bunal-transit | Examiner | Sequantially list conditions, | | Dua to (or as a c | onsequance of): | | | | | | |
| 68760, | se ex clan | | Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disease or Injury | • | | | | | | | | |
| 876 | the b | Medical | that initiated avants rasulting in daath) Last | C. | Due to (or es e co | onsequence of): | | | | | | |
| × | - E 0 | | | . d | | | | | | | | |
| Bo | | Physician/ | | | | | | | | | 1 | |
| o. | 0 0 0 | ysic | Part II. Other significant conditions | contributing to death but | t not rasulting in | tha undarlying causa g | jivan in Part I. | | 23b. Dld tol | bacco use c | ontribute to | the cause of death? |
| ۵. | that the death had by the etter deteched for | | | | | | | | 1 □ Ye | 8 2 No | 3 Prob | bebly 4 Unknown |
| Vital Records, | 8 8 8 | by | | | | | | | | | T | |
| Ö | neen Houl | etec | | | | | | | 24a. Wes an perform | | ava | ra autopsy findings allabla prior to applation of cause |
| 3ec | N S D | Completed | | | | | | | | | | daath? |
| E | F age | S | | | | | | | 1 ☐ Ya | s 2000 | 1 | Yes 2 No |
| /its | Physician: The this certificate rail director, pag | Be | 25. Was casa rafarred to medical exeminar? | | | | | of Death (C | Check only ons | 1) | | |
| 0 | 0 0 | 5 | 1 Yas 2 No | Hospital: 1 Inpatian | | Dalleril SLI DOA | | sing Home | 5 🗆 Rasidar | nca 6XIOt | har (Specify | HOSPICE |
| | ng P uners | - | 27. Mannar of Death Natural 5 ☐ Panding | 28a. Data of Injury (Month, Day | | ma of 28c. Injury | ury at ork? | 280 | I. Dascribe ho | w Injury occu | rred | |
| Sio | Attending or death. ector: After by the fune | cati | 2 Accidant investigati 3 Suicida 8 Could not | | | M 1[|]Yes 2□N | lo | | | | |
| Division | or Attending effer death. Director: After I in by the fune | Certification: | 4 Homicida datarmina | d 28a. Place of Injur building, atc. | ry - At homa, fan (<i>Specify</i>) | n, streat, factory, office | • | 28f. | Location (Str. City or Town, | | bar or Rural | Route Number, |
| | rai Dilled i | | | | | | | | | | | |
| | To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral | edical | 29a. Cartifiar (Check only one) A Certifying P 2 Madical Exa | Physician: To the best of aminer: On the basis of a | axamination and | daath occurred at tha t or Investigetion, in my | tima, data and opinion, deeth | place, and h occurred | dua to tha ca at fhe time, de | usa(s) and m te end place | annar as sta and due to | ated. the ceuse(s) |
| | outh outh | M | 29b. Signatura and title of certifiar | and mannar state | 1 | 29c. Licer | isa number | | 29 | d. Deta sign | ed (Month. I | Day, Year) |
| | - 3 - 0 | | 610 | | 11 | | 0 | | | 00 | / | 100 |
| | | - | 30. Name and address of person who | Completed and | 32C | No Pairs | 133 | 7/5 | | 081 | 1201 | 14/ |
| | | | | | | | E.7000 10 | D 210 | 0.2 | | | |
| | Sta | te | Dr. Eddie Nakhud 31. Data filed (Month, Day, Year) | | | Iey Rd. To | WSOII M | U Z I U | J.) | | | |
| | Registra | | AUG 2 5 199 | 82. Ragistrar | diorKarl | Il. | | | | | | |
| | | | 1.00 00 0 | · // | | | | | | | | |



State of Maryland / Department of Health and Mental Hygiene 97 27 120

| | | | | | | Certificate o | f Death | | Reg. No. | T form | |
|---------------------|--|----------------|---|---|-------------------------------|---|---|-------------------------------------|------------------------------------|---------------------------|---|
| | Dhumin | lan | Decedent's Name (First, Middle, Last) |) | | | | 2. Date of De Month | - | Vone | 3. Time of Death |
| | Physic /Medi | | Charles W. Bye | rs | | | | Augus | | 997 | 5:00 am |
| | Exami | | 4a. Fecility Name (If not institution, give | street and number) | | | 4b. City, Town, or I | Location of Deeth | 4c. County | of Deeth | |
| | | | Carroll County | General | L Hosp | ital | Westmir | | Carr | oll | |
| | Funeral Director | | 5. Social Security Number 215-26-7706 Usuel Residence of Decedent | x 7. Age JM 2□F | (In yrs. lest bi | Months Day | | (Month, Da | h y, Year) /1916 | | olace (State or Foreign otry) Tyland |
| | and and | | 10a. State 10b. County | | 10c. City, Tov | vn or Location | | | | 1 | 0d. Inside City Limits |
| ; | Mary Hard | to | MD Carrol | 1 | West | minster | | | | | 1 ☐ Yes 2√ No |
| : | with the | Director | 10e. Street end Number 720 Stone Road | | | 10f. Zip Code 2115 | | | 10g. Citizen of V | | |
| , | 23 m | eral | | 12. Was Decedent E | iver in LLC | | | poolfs Van ar No | | a - Americ | |
| חצח | s i and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Appiene. If the third marked other than "natural", or frems 23a or 28a-f show other traummite event, the Medical Experiment has notified at | by Funeral | 1 Never Married 2 Married 3 XWidowed 4 Divorced | Armed Forces? 1 X Yes 2 N If Yes, Give Year or Dates: | THE PARTY | 13. Was Decedent of If Yes, specify Co | | o Rican, etc.) | Specify | ck, White, | |
| Maryland 21215-0020 | ithin 72 ho le. San "natur Medical | Completed | 15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) | cation e completed) College (1-4or 5- | | Decedent's Usual Occ (Give kind of work don life. DO NOT use reti | supetion ne during most of wor red) | | 16b. Kind of Br | | |
| 7 | Hygiene. Ther than ent, the M | S | 12 | _ | | Engineer | To a series where | | | | way Adm. |
| anc | over the property of the prope | Be | 17. Father's Name (First, Middle, Last) Denton E. Byer | a | | | 18. Mother's Nen | | | 10) | |
| 2 | snould be and Mental is marked or umatic eve | 10 | 19a. Informant's Name/Relationship (Ty | | 40 | | | | | | |
| Ma | th and 7 is me traum | | C. Dennis Byer | | | o. Mailing Address <i>(Str</i> e 612 Deer | | | | | |
| ψ . | of Health Item 27 I | | 20e. Method of Disposition | 0 00 | | of Disposition (Neme of ory, crametory or other p | | | 20c. Location - | | |
| umore, | rages nent of I ant: If its ary or o | | 1 Burial 2 Cremation 3 R | | | ory, crametory or other p ow Branch | | | | | |
| | 교원관등 . | | 4 □ Donation 5 □ Other (Specify) 21. Signeture of Funeral Servica Licanse | | Meau | 22. Name end Add | | У | westm | inst | er, MD |
| 0 | Depa lmpo any li | | | | | Pritt | s Funera | 1 Home | & Cha | pel | |
| | hysician /Medical Examiner | | 23a. Pert1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition | ie cause on each iiii | 9. | not enter the mode of d | | | | | Approximate Interval Between Onset and Death |
| ٠ | zammer | L. | resulting in deeth) | | | consequenca of): | | | | | |
| 7 | lsit ad | nje | |), | | | | | | | |
| | and al-trar | Examiner | Sequentially list conditions, if any, leeding to immediate | Į. | Due to (ores a | consequenca of): | | | | | |
| | siclan | Je E | cause. Enter Underlying Cause (Disease or Injury that initiated events |), | _ | | | | | | |
| _ | earr cermicate be executed attending physician and for use as the build-transit | in/Medical | resulting in death) Last | f | Oue to (or as a | consequenca of): | | | | | |
| 0 | e atter | sicis | Part II. Other significant conditions con | tributing to death bu | t not resulting i | n the underlying cause | given in Part I. | 23b. Did 1 | obacco use co | ntribute to | the cause of death? |
| ٥, ٦ | igned by the a | by Physician | DIABETES | MELLY | TUS | | | 10 | Yes 2□ No | 3 Prot | bably 4 Unknown |
| necora | s been s 2 should | Completed | | | | | | | en autopsy med? | OO | ere autopsy findings eilable prior to mpletion of cause death? |
| - | D | O | | | | | | 101 | es 2DNo | 1 | Yes 2□ No |
| 2 | certificate rector, pag | Be (| 25. Wes case referred to medical examiner? | | | | 26. Place of Dea | ith (Check only o | ne) | 1 | |
| | this certific | 2 | 1 ☐ Yes 2 ☑ No | lospital: | 1 2 ER/O | utpetient 3 DOA | | ome 5 Resid | lenca 6 □Oth | er (Specify | y) |
| DIVISION OF VITAL | ath. rr: After t | ation: | 27. Menner of Deeth 1 ☑Netural 5 ☐ Pending 2 ☐ Accident investigation | 28e. Dete of Injury (Month, Dey | Year) 28b. | Time of Injury M 28c. In | uryat łork? □Yes 2□No | 28d. Describe h | now injury occur | red | |
| | s after deat al Director: ed in by the | Certification: | 3 ☐ Sulcide 6 ☐ Could not be determined | 28e. Place of Inju- building, etc. | ry - At home, fa (Specify) | arm, street, factory, offic | 8 | 28f. Location (S City or Tox | Straet and Numb m, Stete) | er or Rura | l Route Number, |
| Jacob Man | within 24 hours after death. To the Euneral Director: After completely filled in by the fune | edical | 29e. Certifier (Check only one) 1 Certifying Phys | elcian: To the best of ner: On the basis of and manner stat | examineti <i>on a</i> r | e, death occurred at the nd/or Investigetion, in my | time, date and place opinion, death occu | , end due to the orred et the time, | cause(s) and ma date and plece, | anner as st and due to | teled. the cause(s) |
| 1 | With To the | M | 29b. Signature and title of certifier | | BUDIN | 0- | 21155 | _ | 29d. Dete signe 8 /2 | 2/97 | Dey, Year) |
| | | | 30. Name and address of person who co | mpleted cause of de | eth (Item 23a) | (Type, Print) | | | -/- | 1 , | |
| | | | 4 | MD 9 | 04 W | as huggoi | DW CA | STYNUS | TER 1 | 11) | 21157 |

Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** MIEC EFORCH 19,1997 ANUST /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Toyrr, or Location of Death 4c. County of Deeth Examiner INVIVERSIII Baltimore City 8. Data of Birth (Month, Day, Year) If Undar 24 Hrs. 5. Social Security Number Birthplaca (Stata or Foraign Country) 7. Aga (In yrs. last birthday) **Funeral** Days Months NOW 2 F Hours **Director** 248-74-1722 52 S.C. Usual Rasidance of Decedent with the Maryland 10a Stata 10c. City, Town or Location 10b. County 10d. Insida City Limits rail, or items 23s or 28s-f show Examiner must be notified at MD Harford Aberdeen Director X⊠Xas 2□No 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 46 E. Bel Air Avenue, Apt. #7 21001 USA Peges 1 and 2 should be filed within 72 hours efter death 1 nent of Health and Mental Hygiene.
smit: If item 27 is marked other than "natural", or itema 23, ury or other treumatic event, the Medical Espain or mainty or other treumatic event, the Medical Espain or mainty. Funeral 12. Was Decedant Evar in U,S. Armad Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 □ Yas 2 ☒ No If Yas, Giva Yaar or Datas: 1 Nevar Marriad 20 Married 3altimore, Maryland 21215-0020 1 Yas 2XXVo Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 18b. Kind of Business/Industry Eiamantary/Secondary (0-12) Collaga (1-4or 5+) 10 Truck Driver Truckina 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Meiden Sumema) Be James Brown Albertha Faire 19a. Informant's Neme/Ralationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routs, Number, City or Town, State, Zip Code) Drema Brown/ Wife 46 E. Bel Air Avenue, Apt. #7, Aberdeen, MD 21001 20b. Place of Disposition (Nama of cematary, crematory or other plece) 20e. Mathod of Disposition 20c. Location - City or Town, Stata permit. Peges Department of Important: If its any injury or or XX Burial 2 Cramation 3 Ramoval from Stata 4 Donetion 5 Other (Specify) James Cemetery 8/23/97 Havre de Grace, MD 22. Nama and Addrass of Facility Beard Funeral Home 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or heart failure. List only one cause on each line. Approximata interval Batween Onset and Death Physician /Medical immediata Causa (Finel disaasa or condition rasulting in daath) CEREBRAL HERE 3.5 DHS Examiner Dua to (or as a consequance of): Physician/Medical Examiner INTRACFICEBICAL & HEMURRAGE INTERNATIONAL physician and the buriel-transit The lew requires that the death certificete be executed Sequantially list conditions, if any, leading to immadiate ceuse. Enter Underlying Cause (Disaasa or injury that initiated events resulting in deeth) Last Dua to (or as a consequance of): Box 68760. HYPFETENSION Dua to (or as a consequence of) 80 FENAL FAILURE for use signed by the a P.O. Part il. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Records. þ 24e. Was en autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of deeth? Completed should page 2 1 🗆 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: funeral director, 25. Wes case rafarred to madical axaminar? Be 26. Piaca of Death (Check only ona) Hospitel: 1 ☐ inpatiant 1 Yas 2 No Othar: 4 Nursing Homa 5 Rasidanca 8 Othar (Specify) Certification: To 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mangar of Daath 28b. Tima of injury 28d. Dascribe how injury occurred 28c. Injury at Work? 5 Panding invastigation 1 Neturai 2 Accidant 24 hours efter death. 1 Yas 2 No the 6 Could not be 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) Plece of Injury - At home, tarm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, daath occurred at the time, dete end place, and due to the ceuse(s) end menner as stated.

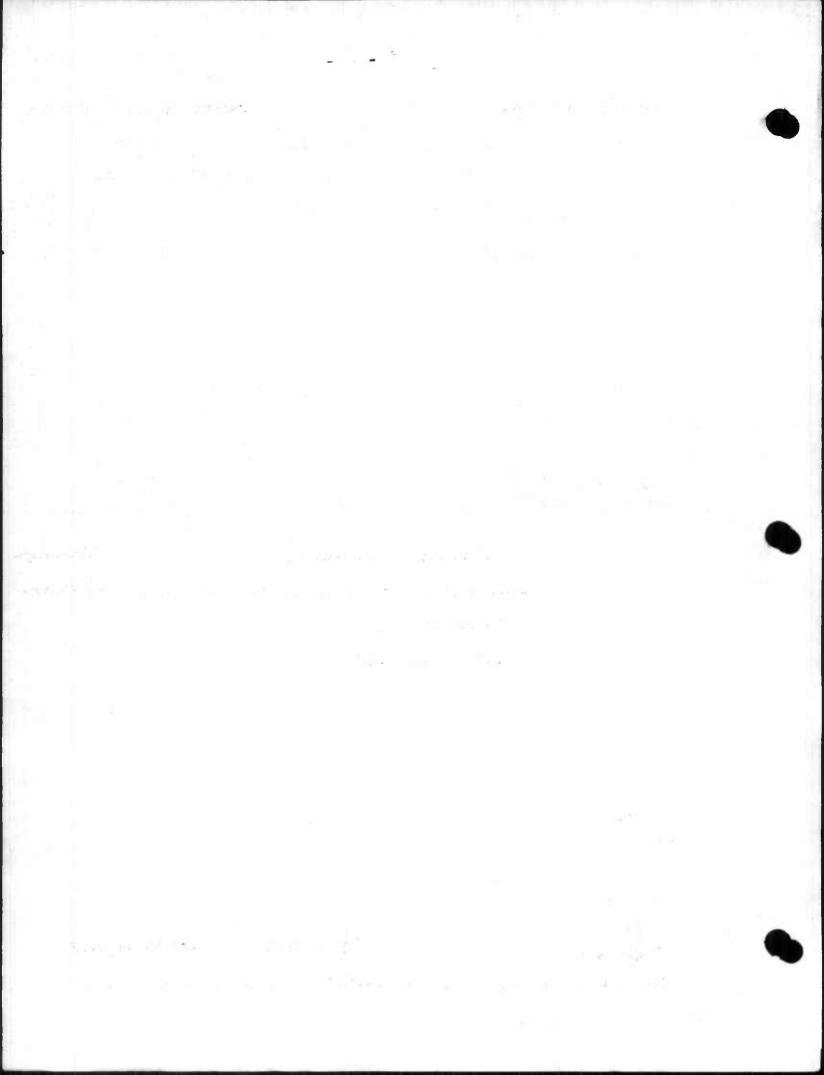
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) end mannar stated. 29e. Certifier edicai (Check only one) within 2 To the ş 29b. Signature and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) 0 racust 19, 1997 0252 77 30. Nama and eddress of person who completed causa of death (Item 23e) (Type, Print) Cook, Jusson BAMMER, MD 22 S. CHORENTS ST MD 31. Data filed (Month, Day, Yaar) 32. Ragistrar's Signatura State

and Shudson Rardall

DHMH 16 Rev 6/95

Registrar

AUG 2 8 1997



State of Maryland / Department of Health and Mental Hygiene 97 27122

| | | | | | | Cei | rtificate | of Deat | th | | Reg. No. | 1 | 411 | 4 |
|------------|---|------------------|---|---|--------------------------|------------------------|---|---------------------------------|-----------------------|---|----------------------------|--------------|---|----------------|
| | Physic /Medi | | Decedent's Name (First, Middle, Las. | Mary | Ε. | Burle | у | | | 2. Date of Dec Month August | eth Day | Year L997 | 3. Time 4:25 | of Death |
| | Exami | | 4e. Facility Neme (If not Institution, give Manor Care — Bet | | | | | | Town, or L | ocation of Deeth | | of Death | | |
| | Funerai Director | | 373 00 1430 | 7. Age | | est birthday) Yrs. | If Under 1 Months E | Year If Und Days Hour | der 24 Hrs. S Min. | 8. Dete of Birth (Month, De) Nov. 9, | 1903 | Cou | ntry) | or Foreign |
| | Maryland -f show | tor | Usual Residence of Decedent 10e. State 10b. County Montg | omery | 10c. City | , Town or Lo | | thesda | | | | 1 | IOd. Inside | City Limits |
| | th with the 23a or 28a | Funeral Director | 10e. Street and Number 6530 Democracy | Blvd. | | | 10f. Zip Co | ode | 2081 | | 10g. Citizen of \ | What Coul | ntry? | |
| 020 | iges 1 end 2 should be filed within 72 hours efter death with the Marylend at of Health and Mental Hygiene. If Item 27 Is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examinat must be notified at | by | 11. Maritai Status 1 X Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent E Armed Forces? 1 Yes 2 XN if Yes, Give Yeer or Dates: | | 1 | Was Deceder if Yes, specify 1 ☐ Yes 2 ☐ | | | pecify Yes or No- Rican, etc.) | 14. Rad Blad Specify | ck, White, | can fndian, etc. hite | |
| 21215-0020 | I within 72 ho iene. • than *natur he Medical | Completed | 15. Decadent's Edi (Specify only highest gred Elementery/Secondary (0-12) | cation de completed) College (1-4or 5- | +) | (Give | dent's Usual C kind of work of DO NOT use | done during n | ost of work | king | 16b. Kind of B | usiness/in | | |
| Maryland: | should be filed nd Mental Hygi marked other umatic event, the | To Be C | 17. Father's Name (First, Middle, Lest) William R. Bu | | | | | 18. Mo | ther's Nam | ne (First, Middle, Unkn | | ne) | | |
| Mar | d 2 sho th and 7 Is me traum | | 19a informant's Name/Relationship (T) Doris B. Maxwell | ype, Print) - Niece | | | ng Address (S Commerj | | | <i>ral Route N</i> um <i>be</i> Boothbay | | | 045 | 3.8 |
| | f Health Item 27 | | 20a. Method of Disposition | 112000 | 20b. Pl | aca of Dispo | sition (Neme | of | | Date | 20c. Location - | | | 50 |
| E C | Pege nent o int: If | | 14 Burial 2 Cremetion 3 ☐F 4 ☐ Donation 5 ☐ Other (Specify) | | _ | | netory or other | | 8 | 3/26/97 | Washing | ton, | D. | C. |
| Baltimore, | permit. Peges 1 en Department of Heal Important: If Item 2 any injury or other once. | | 21. Signature of Funeral Service Licans | Peter | 2) | | Name and A | | cility Jos | seph Gaw ashingto | ler's S | ons | 20016 | |
| | | | 23a. Paur. Enter the disease, or composhock, or heart fallure. List only o | lications that caused ne ceuse on each line | the death | . Do not ent | er the mode o | of dying, such | as cardiec | or respiretory er | rest, | Į Į | Approxim Intervai B Onset and | etween |
| ì | /Medicai | | fmmediate Cause (Final disease or condition | Chr | onic | Organ | nic Bra | in Syn | drome | 2 | | | lO Ye | |
| | Examiner | L | resulting in death) | 0 | Due to (or | as a consec | quence of): | | | | | | | |
| | bed lisit | nine | | ь. Нур | erte | nsion | | | | | | | 20 Ye | ars |
| 60, | be execu cian end buriel-tra | al Examiner | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury | с. | Due to (or | as a conseq | uenca of): | | | | | | | |
| ox 68760, | eath certificete be executed ettending physician end for use es the buriel-transit | n/Medical | that initiated events resulting in death) Last | d | oue to (or | as a conseq | uence of): | | | | | | | |
| Ö. | death he ette red for | Physician | Part II. Other significant conditions co- | ntributing to death but | t not resu | Iting in the u | nderlying cau | se given in Pa | ırt I. | 23b. Did t | obacco use co | ntribute te | o the cause | of death? |
| 0. | requires thet the death ce seen signed by the ettendi hould be detached for use | by Phy | Hyperlipemia | | | | | | | 101 | /es 250 No | 3 □ Pro | bably 4[| Unknow |
| Records, | 28 | Completed I | Urosepsis | | | | | | | | an autopsy med? | av | ere eutops eilable prio mpletion of deeth? | r to |
| | T age | | | | | | | | | 1 U Y | es 2⊡No | 1[| ☐ Yes 2 | □No |
| of Vital | Physician: The this certificate and director, page | o Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ② No | Hospital: | | | | Other | | th (Check only o | | | | |
| on of | ding Ph h. After thi funeral | | 27. Menner of Death 1 Natural 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Dey | / | 28b. Time of Injury | | Injury at Work? 1 □ Yes 2 | | ome 5 Resid | | | γ) | |
| Division | al or Attending s efter death. Il Director: After ed in by the fune | Certification: | 3 Sulcide 6 Could not be determined | 28e. Placa of Injurbuilding, etc. | ry - At hor (Specify) | ne, farm, str | eet, factory, o | ffice | | 28f. Location (S City or Tow | | per or Run | al Route Nu | m <i>ber</i> , |
| | To the Hospital or A within 24 hours efter To the Funeral Direct completely filled in by | edical (| | sician: To the best of ner: On the basis of e end menner stet | examinet | | | | | | | | | o(s) |
| | To the | Me | 29b. Signature and title of certific | lowing | m. | 9. | | Icense numbe | | | 29d. Dete signe August | | | |
| , | • | | 30. Name and address of person who co | | | | | ve. N. | W. | Washing | | | 2000 | 08 |

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 07

| | | | | | State of IVI | arylanu | | ificate of | nealth and i Death | nentai Hy | Reg. No. | 1 2 | 1123 |
|---------------------|---|----------------|--|--------------------------------------|--|------------------------|-------------------------------|---|--|---|--------------------------------------|-----------------------------|---|
| | Dhysio | io- | 1. Decedent's Nema (F | irst, Middle, La | st) | - | | | 4 | 2. Data of De | eeth Dey | Yeer | 3. Time of Deeth |
| | Physici /Medi | | | Villiam | F. Bros | | | | | August | | -997 | 1:55 PM |
| | Examir | ner | 4e. Facility Neme (If no | | | | | | 4b. City, Town, or L | ocation of Deet | h 4c. County | of Deeth | |
| L | | | 2921 N. I | | | vd. | | If Under 1 Yaar | Silver : | Spring | Monte | omer | 7 |
| | Funeral Director | | 5. Social Security Num 577-34-407 | 5 1 | ex 7. Ag | je (In yrs. lesi 67 | | Months Deys | | 8. Deta of Bir (Month, De Nov. 8) | ey, Year) 1929 | 9. Birthpl Count Wash | ece (Stete or Foreign try) ington D.C. |
| | inylend | | Usuel Residence of De 10a. Stete 10 | b. County | | 10c. City, T | Town or Loca | tion | | | | 10 | Od. fnside City Limits |
| | 88-4 s | Director | | Montgom | ery | | Silve | r Spri | ng | | | | 1X Yes 2 □ No |
| | 10 P | Dia | 10e. Street end Numbe | | | | | 10f. Zip Code | 1 | - | 10g. Citizen of V | | ny? |
| | s 23s | erai | 2921 Nort | h Leisu: | | | | | 906 | | - | S.A. | |
| 020 | d within 72 hours effer death with the Maryland Jone. I than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at | by Funeral | 11. Marital Stetus 1 ☐ Never Married 3 ☐ Widowed 4 ☐ | | 12. Wes Decedant Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: | | | es Dacedent of No. Yes, specify Cub Yes 2 No. | Hispenic Origin? (Speen, Maxicen, Puerto Specify: | ecity Yes or No Rican, etc.) | Specify | e - Americe ck, White, e | |
| ŏ | 2 hou | | 15 | . Decedent's Ed | ucation | 1 | 16e. Deceder | nt's Usuel Occup | petion | | 16b. Kind of Bu | | |
| Maryland 21215-0020 | within sne. than | Completed | (Specify of Elementery/Seconds | only highest gre ory (0-12) | de completed) College (1-4or : | | (Give kir life. DC | nd of work done NOT use retire | during most of work | ing | Amto | rok | |
| D | e filed with al Hyglene other than | | 17. Fethar's Name (First | st, Middle, Last) | | | 4.461 | CHITITE | 18. Mother's Nam | e (First, Middle | | | |
| lan | should be and Mentel marked or umatic eve | To Be | Corneli | us | Brosnar | ı | | | Mary | S | heehan | | |
| ary | 2 shot and N is man | _ | 19e. Informent's Neme | /Reletionship (| "ype, Print) | | 19b. Meliing | Address (Street | t end Number or Rui | | | Stete, Zip | Code) |
| | Health a sem 27 is other train | | Patricia l | M. Bross | nan (Wife) |) 2 | 2921 N | orth Le | isure Wor | ld Blvd | .Silver | Sprin | ng, Md. 20906 |
| Baltimore, | 9 6 | | 20a. Method of Disposi 1 ☐ Burlai 2 🖾 C 4 ☐ Donetion 5 [| remetion 3 🗆 | Removal from Stete | cem | etery, creme | ion (Name of tory or other ple Cremato | | Date 8/26/97 | 20c. Location - | | |
| Balti | permit. Peg Department Important: I any injury o | | 21. Signature of Funar | | | / | | lama and Addre | | | Funeral | | |
| <u>5</u> | 4014W | | Show | 11S. | Cham | len | | | mbia Blvd | | | , Md. | . 20910 |
| | | | 23e. Part1. Enter the d shock, or heert fe | liseese, or comp ilure. List only | plicetions thet ceused one ceuse on each li | the deeth. (ne. | Do not enter | the mode of dyi | ng, such es cerdiec | or respiretory a | rrest, | | Approximete Intervel Between Onset and Deeth |
| | Physician // // // // // // // // // // // // // | | Immediete Ceuse (Fine | el. | 0 4 . | | | 11-1 | | 41. | _ | | Onset and Deeth |
| | Examiner | | diseese or condition resulting in deeth) | | . CONSE | | | HEA | 87 F | 41 LUR | <u> </u> | 2 | IEHKS |
| | | Je. | | | CORONA | | s e conseque CLERU | ince of): | EART | DISE | ACT | 8 | YEARS |
| | ificate be executed g physician end es the buriel-transit | Examiner | Sequentielly ilst condit | lons. | b.Corwin | | s e conseque | | | 11106 | 1135 | | ILIINS |
| o, | e exe ian ei uriel-l | | Sequentielly ilst condit if eny, leeding to imme ceuse. Enter Underlylr Ceuse (Diseese or inju thet initieted events | diate | | | | | | | | | |
| 68760, | ate b hysic the b | edicai | thet initiated events resulting in death) Lest | , | C | Dua to (or as | e conseque | nce of): | | | | | |
| | 5 0 0 | | | L. | d | | | | | | | | |
| Вох | attendin for use | lan | | | 0. | | | | | | | | |
| | the s | Physician/M | Pert II. Other significan | nt conditions co | ntributing to death b | ut not rasultin | ng in the unde | erlying ceuse gi | van in Pert I. | 23b. Dld | tobacco uee cor | tribute to | the cause of death? |
| s, P.O. | ires thet the deeth cer signed by the attendir d be detached for use | by Ph | CEREBR | AL 7 | THROMB | 0515 | ; R | ECURR | ENT | | Yee 2□ No | 3 Prob | ably 4 □ Unknown |
| Record | requiper shoul | Completed | ASPRATI | oN; | CHRONI | c 01 | BSTRU | CTIVE | PULMONI | 24e. Was | an autopsy ormed? | eve | re eutopsy findings illeble prior to inpletion of cause leath? |
| | | Com | PISEASE | | | | | | | 10 | Yes 2 No | | Yes 2□ No |
| Zi Ki | certificate rector, pag | Be | 25. Wes case referred exeminer? | - | Hospital: | | | 04 | 26. Plece of Deel | h (Check only | one) | | |
| o | Physical direction | . To | 1 Yes 2 No | | | ent 2 ER | | 3LI DUA | | | dence 6 Other | |) |
| Division of Vital | or Attending Physician: after death. Director: After this certific i in by the funeral director, | tion | 1 Neturel 5 | Pending Investigation | 28e. Date of Inju (Month, De | | b. Time of Injury | 28c. Inju Wo | rk? Yes 2 \sum No | 200. Describe | now injury occurr | 80 | |
| IS | Attendi death ctor: A | fica | | ☐ Could not be | | urv - At home | e, farm, street | | | 28f. Location (| Streat and Numb | er or Rural | Route Number. |
| 2 | after after Direction by | Certification: | 4 Homicide | determined | building, ef | c. (Specify) | | ., | | City or To | | | |
| | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director. After th completely filled in by the funeral | edical C | 29a. Certifier (Check only one) | Certifying Phy Medical Exam | reician: To the best of | examinetion | dge, deeth or and/or inves | ocurred et the ti | me, dete end place, opinion, death occur | and due to the red et the time, | cause(s) and me date end place, a | nner es ste and due to | eted. the ceuse(s) |
| | To the within 2 To the comple | Mec | 29b. Signature and title | of certifier | end menner ste | | | 29c. Licens | se number | T | 29d. Data signed | d (Month, E | Day, Year) |
| | 3 | | Vn 21 | Dn | 10 | 1/2 | un | 0- | 777 | | - | | |
| | , | | 30. Name and address | of parson who | consisted carried of | (Itam 22 | Re) (Tunn Da | inti | 12 | | A06. 2 | 11 | 77/ |
| | | | 2201 N/F | N M | EXICO A | E 1 | LW | MASA | y. D.C. | 200 | 16 | • | |
| | Sta | te | 31. Dete filed (Month) | 16261 | 32. Region | ar's Signature | 72. | J.00 | | - 501 | P | | |
| | Registr | ar | | | | world | man Mark | | | | | | |

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State of Maryland / Department of Health and Mental Hygiene 97 27121.

| _ | | | | | | C | Certifica | | | 2 111011101111 | Reg. No. | 1 4 | 1124 |
|-------------------|--|----------------|---|--|-----------------|------------------------|-------------------------------|----------------------------|-------------------------------------|---|-------------------------|-------------------------------------|--|
| П | Physic | an | Decedent's Neme (First, Middle | le, Last) | | | | | | 2. Date of D Month | Dey | Yeer | 3. Time of Deeth |
| | /Medi Exami | cai | MARTHA JANE I 4e. Fecility Neme (If not institution | | | | | 4 | b. City, Town, | AUGUST or Location of Dea | 25, 19 | | 1:30 AM |
| 4 | LXaiiii | ici | 8905 Woodland | 1 Drive | , | | | | Silver | Carina | | | |
| Н | Funeral | | 5. Social Security Number | 6. Sex 7. A | ge (In yrs. | lest birtho | | der 1 Yeer | If Under 24 F | rs. 8. Dete of B | irth | ntgomer 9. Birthple | ce (Stete or Foreign y) |
| es. | Director | | 125-30-2119 Usuel Residence of Decedent | 1□M 2 ∏ F | 57 | Yr | Month. | ns Deys | Hours M | Jan. 29 | | New Yo | |
| | yland | | 10e. Stete 10b. County | | 10c. Cit | y, Town o | r Location | | | | | 100 | d. Inside City Limits |
| | Mar | to | Maryland Monts | gomery | Si | 1ver | Spri | nα | | | | | 1 ☐ Yes 2 ☑ No |
| | h the | Directo | 10e. Street end Number | 30 | 0.1 | 1001 | | Zip Code | | | 10g. Citizen o | Whet Country | y? |
| | th wil | | 8905 Woodland I |)rive | | | | 2091 | 1 | | U.S. | A | |
| | dea dea | Funeral | 11. Marital Status | 12. Wes Decedent | | S. | 13. Wes De | | | (Specify Yes or Nerto Rican, etc.) | o- 14. R | ace - American | |
| 21215-0020 | s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiena. If Health and Mental Hygiena. Item 27 is marked other than "natural", or liems 23a or 28a-f show other traumatic event, the Medical Evantinar marken in or inclined at | by | 1 ☐ Never Merried 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced | ried 1 ☐ Yes 2 ☐ | No | | | 2 [™] No | | ento Hicani, etc.) | Spec | | |
| 0-10 | 2 hor | P | 15. Deceden | nt's Education | | 16e. D | ecedent's U | suel Occup | etion | | 16b. Kind of | White Business/Indus | |
| 215 | within 7 ena. than "n | Completed | (Specify only highat Eiamantary/Secondary (0-12) | st grade completed) Collaga (1-4or | 54) | (C | Rive kind of fe. DO NO | work done o usa ratired | duning most of a | vorking | | | |
| 2 | d wit | EO. | Clairiana y cocondary (o 12) | 2 | 34) | Hom | emake | r | | | Own H | ome | |
| Maryland | should be filed with and Mental Hygiena. s marked other ther numatic event, me | Be (| 17. Father's Neme (First, Middle, | Last) | | | | | 18. Mothar's N | lama (First, Middle | e, Malden Sum | eme) | |
| ya | Ment Ment arked | 2 | Arthur Macgre | egor | | | | | Amy | Cranda | 11 | | |
| ä | 2 sho and is m | | 19a. Informent's Neme/Relations | ship (Type, Print) | | 19b. M | lailing Addre | ess (Street | end Numbar or | Rural Route Num | ber, City or Tow | n, Stete, Zip C | code) |
| | Health em 27 | | Anthony T. Bros | shkevitch | | 890 | 5 Woo | dland | Drive | Silver | Spring, | Marylan | d 20910 |
| ore | of H of H or off | | 20e. Mathod of Disposition 1 Burial 2 □ Cremetion | 3 □Ramovel from State | 20b. P | lece of D emetery, | isposition (f cremetory o | verne of er other plea | e) | Dete | 20c. Location | n - City or Towr | n, Stete |
| E | Pag ment ant: uny | | 4 □ Donetion 5 □ Other (S | | | e of | Heave | n Cem | etery | 8/28/97 | Silver | Spring | ,Maryland |
| Baltimore, | permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once. | | 21. Signeture of Euneral Service | Licensee | | | | | s of Fecility | | | | |
| ш | 205 20 | | * KACYA. | Stuver. | | | | | | s Funera vd.,W.,S | | | m 20001 |
| Y | Physician | 100 | 23a. Pert1. Enter the disease, or shock, or heart tailure. List | complications that cause only one cause on each I | d the death | n. Do not | enter the m | ode of dyln | g, such es card | liac or respiretory | errest, | l A | Approximete intervel Between Onset end Daath |
| | /Medical Examiner | | Immediate Ceuse (Finel disaesa or condition rasulting in deeth) | e Cardiac | Arre | st | | | | | | | |
| | | <u></u> | rasaning in destily | | | | sequence o | of): | | | | 1 | |
| Т | ted nsit | Examiner | | b. Diabete | s Mel | litu | S | | | | | | |
| -6 | al-tra | хаі | Sequentially list conditions, if any, laading to Immadiate cause. Enter Undarlying Ceuse (Disaase or Injury | | Due to (o | r es e cor | sequence o | of): | | | | | |
| 68760, | death certificate be executed a attending physician and ad for use as the burial-transit | | Cause. Enter Undarrying Ceuse (Disaase or Injury that initiated events | c. Hyperte | | | | 4) | | | | | |
| | rificating physics the | Medical | rasulting in deeth) Lest | 20.00 | | | sequence o | 1): | | | | | |
| Box | | 2 | | d. Ethanol | Abus | e | | | | | | | |
| | that the death ce ed by tha attendir detached for use | Physician/ | Part II. Other significant condition | ons contributing to death i | nut not rasi | ulting in th | e underlyin | n cause oiv | an in Pert I | 23h Die | I tobacco use o | contribute to ti | he cause of death? |
| 0.0 | by the | hys | | one contributing to douter | Jul Hot Tage | annig iir n | ie diluenyin | g cause givi | SIT III F GIL I. | | | | bly 41 Unknown |
| | es tha igned be de | ру Р | Cataracts | | | | | - | | - | | | 2, |
| Records, | - w D | | | | | | | | | | s en eutopsy formed? | | e sutopsy findings eble prior to |
| 000 | aw requisite periors to should be sh | Completed | Arthritis | | - | | | | | - | omear | comp of da | pletion of cause |
| | The law ate has | E | | | | | | | | 1 🗆 | Yas 2 No | 10) | Yes 2□ No |
| ta | | Be C | 25. Wes case referred to medica | I I | | | | | 26. Place of D | Deeth (Check only | | | |
| > | S 00 0 | To | exe <i>m</i> lner? 1 ☐ Yes 2 ☑ No | Hospital: 1 ☐ Inpati | iant 2 | ER/Outpe | etient 3 | DOA Oth | 26- | Home 5 Res | | ther (Specify) | |
| Division of Vital | l or Attending Ph after death. Director: After th d in by the funeral | Certification: | 27. Mannar of Deeth 1 StNatural 5 Pandin 2 Accidant investig | | ury ay Year) | 28b. Tim Inju | re of ry M | 28c. Injun Work | | | how injury occ | | |
| S | Attendir r death. rctor: Al | flca | 3 ☐ Sulcide 6 ☐ Could | not be as Blace of te | iury - At ho | ma, farm | | 1 | 1104 11-1-1 | 28f. Location | (Straat and Nur | nbar or Rural F | Route Number. |
| S | al or A safter I Direct od in by | Serti | 4 ☐ Homicide | building, a | tc. (Specify | 1) | ,, | ,, | | | wn, Steta) | | |
| | To the Hospital or Attending Is within 24 hours after death. To the Funeral Director: After complately filled in by the funer | edical (| 29a. Certifier (Check only one) Certifyin 2 Medical | g Physician: To the best Examiner: On the basis of and manner si | of examinat | wledge, d ion and/o | eeth occurre r Investigeti | ed et the tin | na, data and ple olnion, deeth o | ce, end due to the courred at the time | ceuse(s) end / | nennar es stete s, end dua to th | ed. he cause(s) |
| | of the | Me | 29b. Signeture end title of qertifie | 4 | | | | 29c. License | number | | 29d. Dete sign | ned (Month, De | ey, Year) |
| | 10 | | MA | P 10/1111 ~ | | | | | | | | | |
| | | | 30. Nema and eddrass of parson | who completed cause of | deeth /lta- | 23a) /T. | | 3700 |)2 | | August | 25, 19 | 9/ |
| | | | | | | | | 1 #21/ |) 0:1 | on Comin | Mawel. | and 200 | 10 |
| | Sta | te | Jean Welsh, M 31. Dete filed (Month, Day Year) | 32. Regist | par's Signa | rita , | Rondo | 1 1/31(| SITA | er Spring | s, mai y L | 111d 209 | 10 |
| | Registr | ar | AUGZ | 8 1331 | war war | don,- | Maritan | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 27 1 25

| | | | | | | Certi | ificate of | Death | | Reg. N | lo. | · Con | | |
|---------------------|---|----------------|--|---|-------------------|------------|------------------------------------|---|--|-------------------------------------|--|------------------------|--|--|
| | Dharain | | Decedant's Nama (First, Middla, Last) | | | | | | 2. Data of De Month | | | Voor | 3. Time of Death | |
| | Physic /Medi | | Ada | S. | Bre | in | | | | 3, | 1997 | Year 7 | 9:45am | |
| | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show and important of the marked other than "natural", or items 23s or 28s-1 show and any injury or other traumatic event, the Medical Exponent must be notified as any injury or other traumatic event, the Medical Exponent must be notified as any other. | | 4a. Fecility Nama (If not Institution, giva straet and number) 4b. City, Town, or | | | | | | | eath 4c. County of Death | | | | |
| | | | 1401 Blair mill | Rd. #1617 | | | | Silver | Spring | | Mont | gome | rv | |
| П | | Director | 5. Social Sacurity Number 6. Sex 7. Aga (In yrs. lest birthday) If Under 1 Year If Under | | | | | r If Under 24 Hrs. | 8. Data of Bi (Month, D | | | _ | leca (Stata or Foraign try) | |
| | | | 577–16–8660 | 10 M 210 F 94 | + | Yrs. | Working Days | Tiours Will. | Aug, 4 | | 902 | | gland | |
| | | | Usual Residence of Dacedant | | | | | | | | | | | |
| | | | 10a. Stata 10b. County 10c. City, Town or Location | | | | | | | | 10 | Od. inside City Limits | | |
| | | | | omery | Sil | ver S | Spring | | | | | | 1 ☐ Yas 2 🔼 No | |
| | | | 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? | | | | | | | | | iry? | | |
| | | ra | 1401 Blair Mill Rd. #1617 | | | 20910 | | | | | US | | | |
| Maryland 21215-0020 | | by Funeral | 11. Maritel Status 1 Nevar Marrlad 2 Marrled 3 Widowed 4 Divorced 12. Wes Decedant E Armed Forces? 1 Yas 2 Never Yar or Datas: | | Evar in U,S. | 0 | | | enic Origin? (Specify Yas or No- Mexican, Puerto Rican, atc.) Specify: | | 14. Raca - American Indien Bleck, Whita, atc. Specify: White | | atc. | |
| 2-0 | | ted | 15. Dacadant's | Education | 16a | Decedar | nt's Usual Occu | pation | dilaa | 16b. | Kind of Bu | sinass/Ind | lustry | |
| 21 | | Completed | (Specify only highast grada complated) Elementery/Sacondary (0-12) Collaga (1-4or 5+) | | | lifa. DO | nd of work done NOT usa ratin | Carlo | | | | | | |
| 7 | | 5 | 12 | Acco | ountant | | Government | | | | | | | |
| D | | Be (| 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Name | | | | | | | a (First, Middle, Malden Surnama) | | | | |
| N N | | 10 | Abraham Simon Flor | | | | | | ence Unknown | | | | | |
| a | | | 19a. Informent's Neme/Ralationship | (Type, Print) | 195 | . Melling | Addrass (Stream | it and Number or Ru | rel Route Numb | oer, City | or Town, | Stata, Zip | Code) | |
| | | | Miriam M. Tommer | / Daughter | | | | Rd. Silve | r Sprin | | | | | |
| timore, | | | 20a. Mathod of Disposition 1 N Burial 2 □ Cramation 3 | Removed from State | camate | ry, crame | tion (Nama of tory or other pla | | Date | 20c. Location - City or Town, Stata | | | | |
| Ē | | | 4 Donation 5 Dother Spec | | B'nai | Isra | ael Cem | etery 8/ | /4/97 Oxon 1 | | | Hill, Md. | | |
| a | | | 21. Signature of Funeral Service Lig | episee | | | Name end Addr | | | | | | | |
| 3 | | | CAXOL | | | 100 | ward Sa 91 Rock | gel Funer ville Pik | al Dire | Ctl | on A Ma | 209 | 852 | |
| | Physician /Medical | | 23a Part. Enter the linease, or co | mplications that caused | tha daath. Do | not antar | tha mode of dy | ing, such as cardiac | or respiratory | arrest, | e, 110 | . 200 | Approximate | |
| | | | 23. Fall. Enter the bases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate intervel Between Onsat and Deeth Immediate Cause (Final disease or condition Aspiration Preumonia Let only one cause on each line. Aspiration Preumonia Let only one cause of the letter of the lett | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | Examiner | | rasulting in daath) | | Dua to (or as a | | | | | | | | | |
| | D 45 | Examiner | _ | | | | | | | | | | | |
| | icate be axecuted physician and s the burial-transit | am | Sequantially list conditions, if any, leading to immediate | | | | | | | | | | | |
| Ö, | rifficate be axecuted ng physician and as the burial-transit | | causa. Entar Undarlying Cause (Disaasa or Injury | | | | | | | | | 1 | | |
| 68760, | ate thysic the b | Medicai | that initiated events rasulting In death) Last | C | Due to (or es a o | consaqua | nce of): | | | | | | | |
| Ø | E Da | | | | | | | | | 1 | | | | |
| Вох | The law requires that the death ce see has been signed by the attendir page 2 should be datached for use | lan/ | | d | 11 | | | | | | | | | |
| 0 | | Physician/ | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did | tobacc | o uae con | tribute to | the cause of death? | |
| J. | | | Congestive Heart Failure | | | | | | 1 Yes 2 No 3 Probably 4 Unknown | | | | | |
| Š, | signe d be c | b | | | | | | | | | T | | | |
| Records, | v require been si should | Completed | Atrial Fibrillation | | | | | | 24a. Was perf | performed? aveilebla p | | | ora autopsy tindings bilebla prior to applation of cause | |
| e e | e law has b | du | | | | | | | of death? | | | | | |
| | To the Hospital or Attanding Physician: The Is within 24 bours after death. To the Funeral Director: After this certificate ha complately filled in by the funeral director, page | ပ္ပြ | | | | | | | 19 | Yas : | 2 1 No | 1□ | Yas 2 No | |
| Ita | | Be | 25. Was casa refarred to medical examinar? | | | | | 26. Placa of Daa | th (Check only | ona) | | | | |
| = | | 2 | 1 Yas 2 No | Hospital: 1 Inpatiant 2 ER/Outpetient 3 DOA Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) | | | | | | | | | | |
| 2 | | | 27. Mannar of Death 1 Natural 5 □ Panding | 28a. Date of Injury (Month, Dey Year) 28b. Tima of Injury Work? 28d. Dasc | | | | | | how Inj | ury occurr | ed | | |
| 0 | | cati | 2 Accidant invastigation M 1 Yas 2 N | | | | | | | | | | | |
| Division of Vital | | Certification: | 3 ☐ Suicida 4 ☐ Homlcida 6 ☐ Could not be determined 28e. Plece of Injury - At homa, farm, street, factory, of building, afc. (Spacify) | | | | | ry, office 28f. Location (Straat and Number or Rural Routa Numb City or Town, Stete) | | | Routa Number, | | | |
| ם | | | | | | | | | | | | | | |
| | Hosp 14 hou Fune taly fi | Medical | 29e. Certifier (Check only (Ch | | | | | | | | | | | |
| | within 2 To the | | one) and manner stated. | | | | | | | 29d. Data signed (Month, Day, Year) | | | | |
| | | | 29b. Signature and titla of cartifier | 1~~ | mp | | _ | - | | | | | | |
| | 30 | | Hear Direct | | | | | | August 4, 1997 Wheaton, MD 20906 | | | | | |
| | | | Nema and address of person who | completed cause of de | eath (Item 23a) | (Type, Pri | int) | νc Ω | LAND AND | lan | ms | 2 | nanla | |
| | | | 31. Dete filed (Month, Dall 1990) | cr inv | 244 | / | LEA.IR | ra Dr | Wheal | 01) | עוזי | 0 | 2700 | |
| | Sta | ite | on both mod (Mornin, 47Ud) 5 | 1997 32. Hegiste | r's Signature | - | | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene 97 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Deeth 3. Time of Death Month Bader August 26,1997 8:00am 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth 1919 Aventurine Way Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 1 M 2 XF 64 Months Deys Hours Yrs. Feb.5,1933 PA 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? Aventurine Way 20904 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 ☐ Yes 2 No Specify: SpecifiWhite 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion
(Give kind of work done during most of working
life. DO NOT use retired)
Administrative 16b. Kind of Business/Industry College (1-4or 5+) Georgetown Elementary/Secondary (0-12) University Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Edward Cohen Reba Silansky 19s. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) 1919 Aventurine Way Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State O Burial 2 ☐ Cremation 4 □ Donation 5 □ Other (Spe Judean Mem. Gdns. 8/28/97 Olney, MD 22. Name and Address of Facility Ives-Pearson Funeral Homes Wilson Blvd. Arlington, VA 22201 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Part it. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evaliable prior to completion of cause of death? 24a. Was en eutopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case raferred to medical 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

> 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, deta end place, end due to the cause(s) end menner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

> > 29d Date signed (Month, Dey, Year)

Division of Vital Records, P.O. Box 68760,

Examiner The law requires that the death certificate be exec 8 use as signed by t certificata has or Attending Physician: After this in by the funeral s after death To the Hospital o within 24 hours af To the Funeral Di completely filled is

Physician

/Medical

Examiner

Funeral

Director

than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

flied within 72 hours aftar death with

Pages 1 and 2 should be nent of Health and Mental

verificem 27 is n verificem 27 is n

Department of Important: If any injury or

Physician

Baltimore, Maryland 21215-0020

Gloria

5. Sociel Security Number

10e. Street end Number

Hyman Bader

20s. Method of Disposition

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury

10a. State

1919

Director

þ

Completed

Be

Physician/Medical Examiner

þ

Completed

Be

Medical Certification: To

1 Yes

27. Menner of Death

1 Netural

2 Accident

3 Sulcide

29a. Certifier

4 Homloida

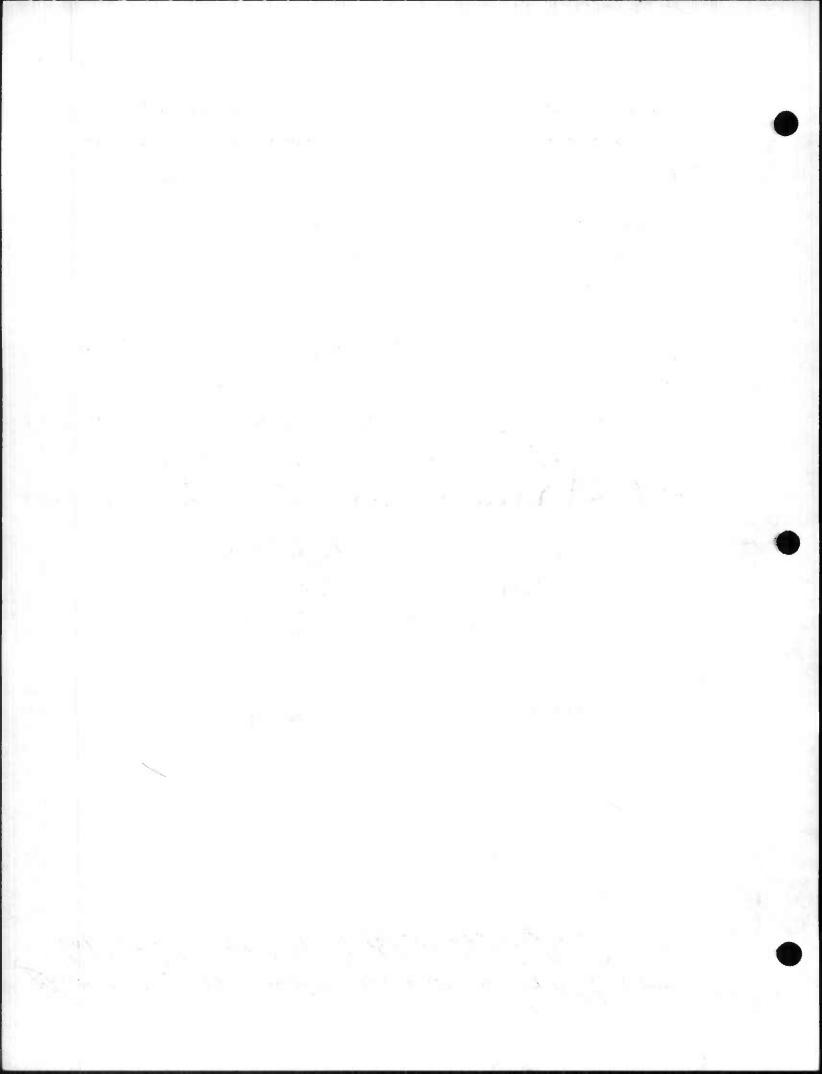
2 No

29b. Signature end titla of certifie

174-26-7187

Usual Residence of Decedant

State Registrar



State of Maryland / Department of Health and Mental Hygiene 9/

| e. | 2 | 7 | 2 | 7 | |
|----|---|---|---|---|--|
| | | | | | |

| | | | | | Certi | ficate of | Death | | Reg. No. | | | | | |
|---|----------------|---|--|---|----------------------|-----------------------------------|--|-------------------------------|--|--|----------------------|--|--|--|
| Dharak | | Decedant's Nema (First, Middle | , Last) | | | 11 | | 2. Date of De Month | | Vana | 3. Time of Death | | | |
| Physic /Med | | MARY | EVELYN | | CAVEY | | | | | | 4:30 P M | | | |
| Exam | | 4e. Facility Nama (If not institution | give streat end nu | mber) | | | 4b. City, Town, or L | | | - 17 | | | | |
| | | 816 ANDOVER RO | AD | | | | LINTHI | CUM | Al | INE A | RUNDET. | | | |
| Funera | | 5. Social Security Number | 6. Sex | 7. Aga (In yrs. last | | f Under 1 Year | If Under 24 Hrs. | 8. Data of Bir | th | Dey Yaar 7, 1997 4:30 P, 9. Birthplace (State or Fora Country) 1911 MARYLAND 10d. finside City Lim 1 Yes 2 R. Citizen of What Country? U.S.A. 14. Rece - Amarican Indian, Black, Whita, atc. Specify: WHITE D. Kind of Businass/Industry OWN HOME dan Sumama) PEARL KISN Ity or Town, Stata, Zip Code) 1, MD. 21090 C. Location - City or Town, State ELKRIDGE, MARYLAND PUNERAL HOME, BURNIE, MD. 21061 Approximata interval Batween Onset and Deeth Live. II M. Coco use contribute to the cause of deet and Deeth Live. II M. Live State of Fora Country? Approximata interval Batween Onset and Deeth Live. II M. Live. II M | | | | |
| Directo | | 212-26-8906 | 1□M 2√2F | 85 | Yrs. | Months Deys | Hours Min. | | | | | | | |
| 7 - | 7 | Usual Rasidance of Dacadant | | | | | | | | | | | | |
| show dat | | 10a. Stata 10b. County | | 10c. City, 1 | own or Local | ion | | | | 1 | | | | |
| ith the M or 288-f se.notifie | 55 | MARYLAND ANNI | E ARUNDEL | I | INTHI | CUM | | | | | TU Yes 211No | | | |
| with the Maryland a or 28a-f show Lbs.notified.at | Director | 10e. Street and Number | | | | 10f. Zlp Coda | | | Death Dey Yaar 3. Time of Death Dey Yaar 4:30 P. ST 17, 1997 4:30 P. eath 4c. County of Death ANNE ARUNDEL Birth Day, Year) 9. Birthplace (State or Foraig Country) 4, 1911 MARYLAND 10d. finside City Limit 1 | | | | | |
| 123 F | | 816 ANDOVER ROA | AD | | | | 21090 | | U.S. | Dey Yaar 17, 1997 4:30 P.M. 4:30 P.M. 4:30 P.M. 4:30 P.M. ANNE ARUNDEL 9. Birthplace (State or Foraign Country) 1911 MARYLAND 10d. finside City Limits 1 Yes 2 No. 14. Rece - Amarican Indian, Black, Whita, atc. Specify: WHITE 16b. Kind of Buelnass/Industry OWN HOME State or Foraign Country? U.S.A. 14. Rece - Amarican Indian, Black, Whita, atc. Specify: WHITE 16b. Kind of Buelnass/Industry OWN HOME State or Foraign Country? U.S.A. 14. Rece - Amarican Indian, Black, Whita, atc. Specify: WHITE 16b. Kind of Buelnass/Industry OWN HOME State or Foraign WHITE 16b. Kind of Buelnass/Industry OWN HOME State or Town, State, Zip Code) JM, MD. 21090 10c. Location - City or Town, State ELKRIDGE, MARYLAND FUNERAL HOME, BURNIE, MD. 21061 St. Approximata Interval Batween Onset and Deeth Onset and Deeth Onset and Deeth I.W. (I More) 1 Yas 2 No. | | | | |
| 5-0020 72 hours after death with the Maryla radural, or terms 23a or 28a-f shordles Examiner must be notified at | Funeral | 11. Maritel Status | 12. Wes Dec | edant Evar In U,S. prces? | 13. We | s Decedant of I | Hispanic Origin? (Si an, Maxican, Puart | pecify Yas or No | 14. Red | | | | | |
| 5-0020 72 hours after natural*, or its fical Examina | | 1 Never Merried 2 Marri | ed 1 ☐ Yas If Yes, Gi | 2 X No | | Yes 2√2 No | | , | 100000 | | | | | |
| End our | d by | X3√□ Widowed 4 □ Divorced | Yeer or D | etes: | | -X | | | Specin | · | WHITE | | | |
| 72 hc | Completed | 15. Decedent (Specify only highes | | 1 | 6a. Decedan | t's Usual Occup d of work done | pation during most of work | kina | 16b. Kind of B | usinass/Ind | dustry | | | |
| | 효 | Elementary/Secondary (0-12) | College (| 1-4or 5+) | life. DO | NOT use retire | during most of word) | | | | | | | |
| and 212 be filed withing tal Hygiene. d other than event, the Me | 8 | / | N/A | | ŀ | IOMEMAKI | | | | | | | | |
| at yield a should be filed of Mental Hyg marked other medic event, I | Be | 17. Fethar's Nama (First, Middle, I | | | | | - 11111 | ne (First, Middla | , Maidan Suman | na) | | | | |
| y lan build be Mental arkad o | 10 | GEORGE | EORGE CAMPION LOTTIE PEA Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or | | | | | | | | | | | |
| de d | | 19a. Informant's Name/Ralationsh | ip (Type, Print) | | 19b. Malling | Addrass (Street | t end Number or Ru | ral Routa Numb | er, City or Town, | Stata, Zip | Code) | | | |
| | | | CESTER E. CAVEY, JR. (SON) 816 1/2 ANDOVER ROAD, LINTHICUM, MD. 21090 | | | | | | | | | | | |
| D SECTO | | 20a. Mathod of Disposition | od of Disposition 20b. Place of Disposition (Nama of cematery, cramatory or other place) | | | | | | | | | | | |
| nit. Pag autment ortant: I Injury o | | 4 □ Doriation 5 □ Other (Sp | of Disposition of Disposition (Nama of cematery, cramatory or other place) 20b. Place of Disposition (Nama of cematery, cramatory or other place) MEADOWRIDGE MEMORIAL PARK 20b. Place of Disposition (Nama of cematery, cramatory or other place) MEADOWRIDGE MEMORIAL PARK 20c. Location - City or Town, State 8/20/97 ELKRIDGE, MARYLAND | | | | | | | | | | | |
| parmit. Pages 1 st Department of Hea Important: if Item; any Injury or other | | 21. Signature of Funeral Service L | Censee | | 22. N | ama end Addra | ass of Facility S | INGLETO | | | | | | |
| 28558 | | b b. VI | X. | | 1 8 | ECOND A | AVENUE, S | .W., GLI | EN BURNI | E, MI | 21061 | | | |
| Paula | | 23x Paul . Enter tha disaasa, or a shock, or heart fellure. List of | complications that of | caused the daeth. [| | | | | | | | | | |
| Physician | | ahook, or heart fellure. List of | only one cause on e | ech lina. | | | | A. 100 | | į | Intarval Batween | | | |
| /Medical | | fmmediate Ceusa (Final | | - 1912 A A- | | | · · | | | į | | | | |
| Examiner | | disaasa or condition resulting in death) | a | | | | | | | i | lugr. II mos | | | |
| | <u>6</u> | | tramediate Ceusa (Final disease or condition resulting in death) Due to (or as a consequence of): | | | | | | | | | | | |
| icete be executed physician and s the buriel-transit | Examiner | Contribution (page 10) and 10 | b | Dua to (or as | | , of), | | | | | | | | |
| exec n an fei-tr | Exa | Sequantially list conditions, if any, laading to immadiate causa. Entar Undarlying Cause (Diseasa or injury | | Dua to (or as | a consequal | ice or): | | | | I I | | | | |
| flicete be exe physician a | Cal | Cause (Diseasa or injury that initiated avants | c | Due to fee as | | | | | | | | | | |
| tificet g phy as the | Medical | resulting in death) Last | | Dua to (or as | a consequar | ica or): | | | | 1 | | | | |
| ath certif attending for use as | 2 | | d | | | | | | | | | | | |
| eath ce attendii | clai | | | | | | | 1 | | | | | | |
| thet the death ce ed by the attendi detached for use | Physician/ | Pert II. Other afgnificant condition | s contributing to de | eath but not rasultin | g in the unde | rrylng causa gi | van in Part I. | | | | | | | |
| es that igned b | | | | | | | | 10 | Yes 2LINo | 3 ☐ Prol | bably 4 Unknow | | | |
| sign sign d be | d by | | | | | | | 24a Was | an autoney | 24h W | are autoney findings | | | |
| require been s should | ete | | | | | | | | | avi | allable prior to | | | |
| he law requires the hes been signed age 2 should be contact the contact the law signed age 2 should be contact the law signed be contact the law signed be contact the law signed age 2 should be contact the law signed age 2 should be contact the law signed age. | Id I | | | | | | | | | of | death? | | | |
| The page | Completed | | | | | | | 10 | Yas 2 No | 10 | Yas 21 No | | | |
| ysician: The is s certificate he director, page | Be | 25. Was casa rafarred to medical exeminar? | 114:-5-1 | | | | 26. Placa of Dea | th (Check only | ona) | | | | | |
| Physic this or | 2 | 1 ☐ Yas 2 ☐ No | | | /Outpatient | 3LI DOA | har: 4 Nursing H | | | | y) | | | |
| Attending Physician: The law requires that the death certificate be executed and additional to the continuous physician and ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the buriel-transit | on: | 27. Manner of Deeth 1 Natural 5 □ Pending | 26a. Data (Mont | of fnjury 28 th, Day Year) | b. Tima of Injury | 28c. fnju Wo | | 28d. Dascribe | how Injury occur | red | | | | |
| or Attending Physicien: T after death. Director: After this certificat I in by the funeral director, p. | Certification: | 2 Accidant investig | ation | | | | Yas 2□No | | 14. Rece - Amarican Indian, Black, Whita, atc. Specify: WHITE 16b. Kind of Businass/Industry OWN HOME Maiden Sumama) PEARL KISNE PEARL KISNE OF, City or Town, Stata, Zip Code) CUM, MD. 21090 20c. Location - City or Town, State ELKRIDGE, MARYLAND N FUNERAL HOME, EN BURNIE, MD. 21061 Approximata Interval Batween Onset and Deeth Onset and Deeth LUY. (1 mos) tobacco use contribute to the cause of death? Yes 21 No 3 Probably 4 Unknown as an autopsy ormed? 24b. Ware autopsy findings available prior to completion of cause of death? Yas 2 No 1 Yas 2 No ona) danca 8 Other (Specify) how Injury occurred | | | | | |
| r Att | = | 3 Suicide 8 Could no 4 Homlolde datarmin | 28a. Placa buildii | of Injury - At homa ng, atc. (Specify) | , farm, streat | , factory, offica | | 28f. Location (City or To | Straat and Numb wn, Stata) | per or Rura | I Routa Number, | | | |
| To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral process. | | | | | | | | | | | | | | |
| Hospital 24 hours Funeral i | edical | 29a. Certifier 1 Certifying | Physician: To the | best of my knowled | dge, death od | curred at tha th | ma, date and place | and due to the | cause(s) and ma | annar as st | ated. | | | |
| in 24 the F | 8 | one) | and meni | ner steted. | and of inves | ugation, in my (| ויטווויקע, daath occul | rec at the time, | vata and place, | and dua to | una Causa(s) | | | |
| To the To the Com | Σ | 29b. Signatura and titla of cartifiar | | | | 29c. Licans | sa nu <i>m</i> ber | | 29d. Data signe | d (Month, | Day, Year) | | | |
| | | gn-Oth | an | | | D4 | 0850 | | August | - 18, | 1997 | | | |
| | | 30. Name and addrass of person w | no complated caus | a of daeth (Itam 23 | a) (Type, Prir | | | | 0 | | • | | | |
| | 1 | | | | -2 / - 2 hoot a lat | | | | | | | | | |

State Registrar YVUNNE

31. Date filed (Month, Day, Year) 32. AUG 1 9 1997

32. Registrar's Signature

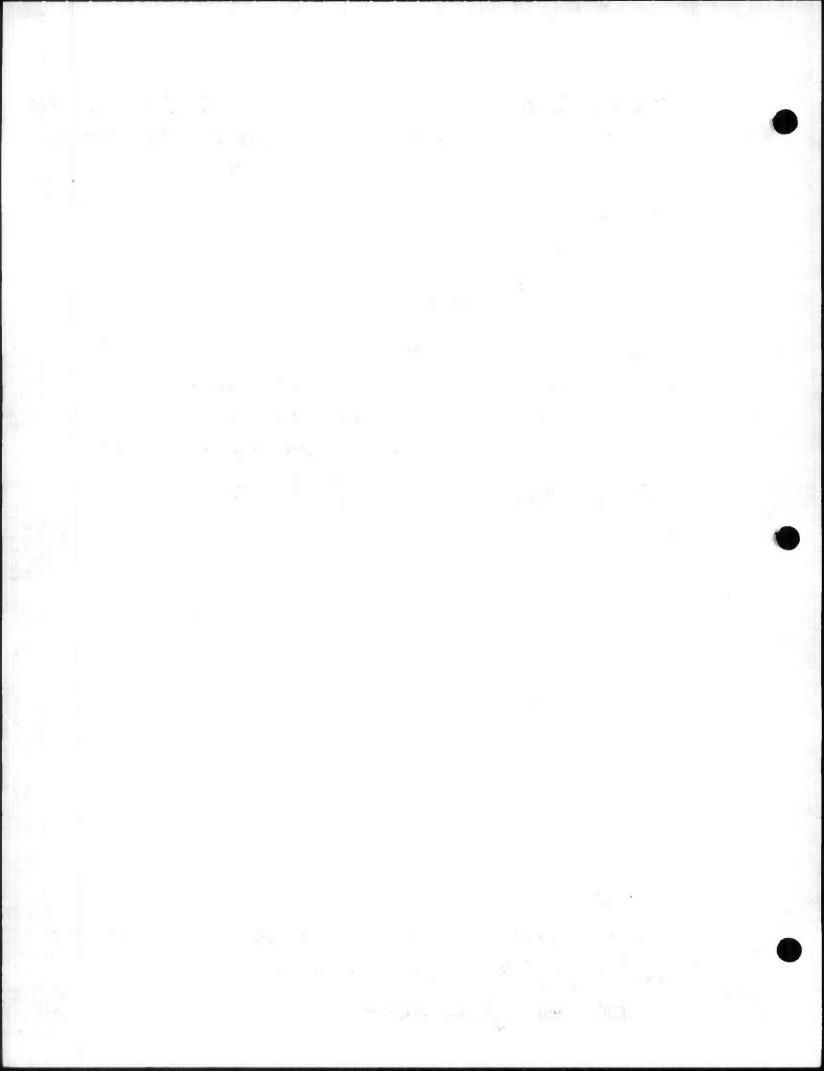
OTTAVIANO MD 900 CATON AVE BALTIMORE MD 21229

1,97

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|---|---|---|-----|-----|---|---|---|
| State of Maryland / Department of Health and Mental Hygiene | q | 7 | 2 | 7 | 1 | 2 | 8 |
| Cartificate of Dooth | - | | 600 | II. | ı | - | 0 |

| | | | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | Cei | tificate of | | | Reg. No. | 4 | 1120 |
|---|---|----------------|---|---|---|-------------------------|--|--|---|--------------------------------------|--------------------------|---|
| | hysici | | 1. Decedent's Name (First, Middla, La | on tec | | | | | 2. Date of D | | 2894 | 3. Time of Death 2: 34 Au |
| | /Medid Examir | | 4e. Facility Name (If non-institution, ph | re street and number | 1 (0) | | | 4b. City, Town, or | Location of Dea | th 4c. County | of Death | 1011 /1 |
| | | | 5. Social Security Number | 1 Media | Age (In yes, last | iter | If Under 1 Yea | HNN If Under 24 Hr | 0001/5 8. Date of Bi | HAM | IE IT | runael |
| Dir | ineral rector | | | 180 M 2□ F | 46 | Yrs. | Months Days | | | 19 1951 | D. C. | place (Stata or Foraign htry) |
| nyland | thow tet | | 10a. State 10b. County | W.D.D.I | 10c. City, T | | | | | | 1 | 0d. Inside City Limits |
| he M | a or 28a-f show be notified at | Director | MARYLAND ANNE ARU | INDEL | ANNA | POLIS | | | | | | 1 ☐ Yes 2 ☐ No |
| ath with | s 23a or | | 10e. Street end Number 632 GREENBRIAN | | | | | 401 | | 10g. Citizen of V | | |
| 21215-0020 d within 72 hours after death with the Maryland giene. | natural', or items 23a adical Examiner must | by Funeral | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Deceder Armed Force: 1 X Yes 2 [If Yes, Give Year or Dates | s? | | Nes Decedent of I Yes, specify Cu | Hispanic Origin? (ban, Mexican, Pue | Specify Yes or Norto Rican, etc.) | Specify | ck, White, | |
| 15-0 | 7 is marked other than "natur traumatic event, the Medical | Completed | 15. Decedent's E (Specify only highast gra | ducetion ada complatad) | 11 | 6a. Deced | lent's Usuei Occu | upetion a during most of wo | orking | 16b. Kind of Bi | usiness/ind | dustry |
| d 2121 filed within Hygiene. | than the Me | Jump | Elementary/Secondary (0-12) | College (1-4o | r 5+) | | OO NOT use retir | | | US NAVA | L ACA | ADEMY |
| | other | Be Co | 17. Father's Neme (First, Middle, Last | | | TILOI | IMMIO NO | | ime (First, Middle | , Maidan Suman | | |
| arylan should be | marked other imatic event, | To B | william j. coate | es | | | | MARY | L. WILS | NC | | |
| 0 0 | Taum. | | 19a. informant's Neme/Relationship (| | | | | et and Numbar or F | | | | Coda) |
| 6 - 6 | or other tr | | FAYE COATES (WIF) 20a. Method of Disposition | E) | | | sition (Nama of natory or other pl | AR LANE A | Date | 20c. Location - | | nwn State |
| F 9 9 | Jury or | | 1 ☒ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification) | y) | e MARY | LAND | VETERAN | CEMETER | | 97 CROWN | | |
| Balt permit. Departm | any injury | | 21. Signature of Funeral Service Licer | Reese | 22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 2140 | | | | | | | |
| | | | 23a. Part1. Enter the disease, or com shock, or heart failure. List only | plications that ceus one cause on each | ed the death. D | o not ente | or the mode of dy | ring, such es cardie | c or respiratory | rrest, | | Approximete Interval Between Onsel and Deeth |
| | ician dicai niner | J C | Immediate Ceuse (Final disease or condition resulting in death) | a accel | temy Due to (or as | OCA a conseq | rdial 1 | rybretu | m | | u | inknown |
| Geath certificate be executed | physicien and the buriel-transit | ai Examiner | Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury | b | Due to (or es | a conseq | uence of): | | | | 1 | |
| BOX 68/60, | 0 0 | in/Medical | that initiated events resulting in death) Last | d | Due to (or as | a consequ | uence of): | | | | | |
| a death | ed for | Physician/ | Part II. Other significant conditions o | ontributing to death | but not resulting | g in the un | derlying cause g | iven in Part I. | 23b. Did | tobacco uss co | ntributs to | the cause of death? |
| S, F.O. | be datached f | by Phy | | | | | | | 1 | Yes 2□ No | 3 Prot | bebly 4 Unknown |
| ecord aw requir | ge 2 should ! | Completed | | | | | | | | an autopsy ormed? | ava | ere eutopsy findings allable prior to mpletion of ceuse death? |
| VITAI H | r, page | | | | | | | | 10 | Yes 212 No | 1 🗆 | Yes 2 No |
| OT VITA Physician: | | o Be | 25. Was case referred to medical exagener? 1 ☑ Yes, 2 □ No | Hospitai: | tient 2 PER/ | Outpatient | 3DE DOA | ther: | ath (Check only | one) dence 6 □Oth | ar (Snacih | 4 |
| VISION OF | tuneral | - - | 27. Manner of Death 1 Matural 5 Pending investigation | 28a. Date of In (Month, D | | . Time of Injury | 28c. Inju | | | how injury occurs | | , |
| 5 646 | d in by the | Certification: | 3 Suicide 6 Could not be determined | 288. Place of II | njury - At home, etc. (Specify) | farm, stre | et, factory, office | | 28f. Location (City or To | Streat and Numb wn, Stata) | er or Rura | l Route Number, |
| Hospital 24 hours | completely filled in by | edical C | 29a. Certifier 1 Oertifying Ph (Check only one) | ysician: To the besininer: On the basis and manner s | of examinetion | ge, deeth and/or Inv | occurred et the t estigation, in my | ime, date and plac opinion, death occ | e, and due to the urred at the time, | cause(s) and me date and place, o | nner as st and due to | ated. the cause(s) |
| To the | сошр | - | 29b. Signature and title of certifier | m) MA | | | 29c. Licen | 128640 | 2 | 29d. Date signed | Month, I | Day, Year) 1997 |
| | | - | JUIL History | completed ceuse of | death (Item 23s | (Type, F | Print) / / A | 711111 | | 1,09 | 10/ | 1111 |
| | - 0 | | 31. Date filed (Month, Day, Year) | 32 Bario | trar's Signature | TUN | M | 21117 | | | | |
| R | Stat egistra | | AUC 1 0 10 | | | - 70m | delle | | | | | |

DHMH 16 Rev 6/95



3. TIME OF DEATH

1 - FOR STATE REGISTRAR

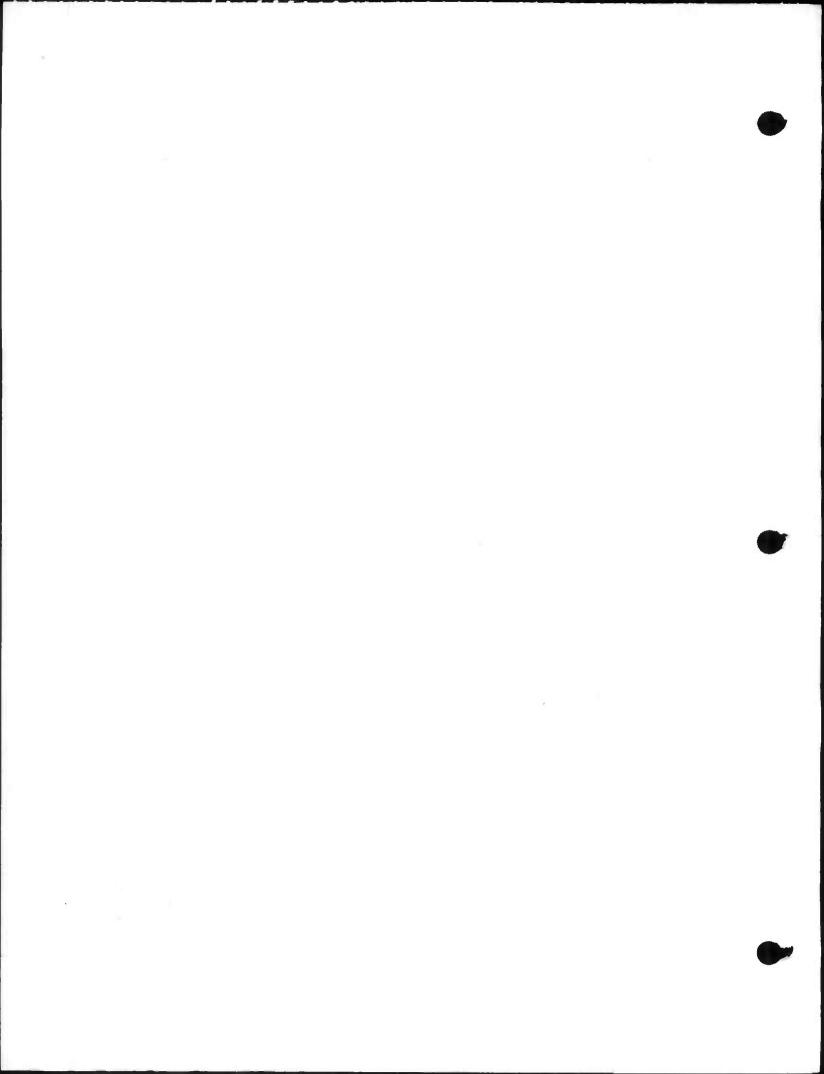
t. DECEDENT'S NAME (First, Middle, Last)

| | 7.7 | - |
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| 90 | within | |
| 687 | executed | |
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| N C | that | |
| RECO | requires | |
| _ | AR! | |
| A | The | |
| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 | |
| SION | ENDING | - |
| Ĭ | A | į |
| 5 | OR | 4 |
| | HOSPITAL | A STATE OF THE REAL PROPERTY. |
| | ૠ | 1 |
| | 2 | |

| | | CLARA L. | COA | TE | <u> </u> | | | AUG | UST / | 4 1 | 1997 2.30 m | |
|--|-------------------------------------|--|---------------------|--|--|-----------------------------------|------------------------------------|--------------------|--|-------------|--|--|
| | | 4. SOCIAL SECURITY NUMBER | | 8. AGE (In yrs | lest birthday) | IF UNDER 1 YEAR | IF UNDER 24 HF | M (Mon | E OF BIRTH oth, Day, Year) | | B. BIRTHPLACE (State or Foreign Country) | |
| 95 | | 215-09-4612 | 1 M 2 F | 90 | YRS. | | | DCT. | 23 19 | | D.C. | |
| 3 should | œ | 9a. FACILITY NAME (If not institution, give s | | | | | OR LOCATION O | OF DEATH | | | D. C. D. | |
| 1. 2, | 6 | MILLENNIUN HEALTH | & KEHAB. | | | GLEN : | BURNEE | | | ANN | E ARUNDEL | |
| sade | DIRECTOR | 10e. STATE 10b. COUNT | Υ | | 10c. CITY | TOWN OR LOCA | TION | | | | | |
| nit. P | | | ARUNDEL | | ANNA | POLIS | | | | | | |
| t per | RAL | 10e. STREET AND NUMBER | | | | 1 | of. ZIP CODE | | | 10g. CITIZ | EN OF WHAT COUNTRY? | |
| the burial-transit permit. Pages | FUNERAL | 1822 F. COPELAND | | | | | 2140 | | | | | |
| ourial | - 1 | 1 Never Merried 2 Merried | 12. WAS DECEDENT | YES 2 | | If yes, s | CENDENT OF HIS pecify Cuben, Me | exicen, Puerto | IN? (Specify Yes Ricen, etc.) | or No- | Black, White, etc. | |
| the | B | 3 🕅 Widowed 4 🗌 Divorced | IF YES, GIVE WAI | H OH DAIES | | 1 U YE | S 2 1 NO S¢ | pecify: | | | BLACK | |
| use as | ETED. | 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | 16e. | DECEDENT'S U | JSUAL OCCUPAT | ION ost of working | 16 | b. KIND OF BUS | INESS/INDU | STRY | |
| | | Elementary/Secondary (0-12) | College (1-4 or 5+) | | life. Do NOT use | retired.) | out at working | | | | | |
| detached once. | COMPL | 7th | - | | DU | MESTIC | | | | | HOME | |
| at on | - | 17. FATHER'S NAME (First, Middle, Last) JAMES WILLIAMSO | N | | | | | | FORTE | | | |
| | BE | 19e. INFORMANT'S NAME (Type/Print) | | | 195 MAILING | ADDRESS (Street | | | | | | |
| 5 should notified | 임 | RUTH ALLEN | | - 1 | | ROYAL | | | | | 200e) | |
| page t be | | 20e. METHOD OF DISPOSITION | | 20b. PLA | | F DISPOSITION (A | | DA | | | Ity or Town, State | |
| must | | 1 X Buriel 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | oval from State | ANNA! | OLIS M | ner place) IEM. GAI | RDENS | 8/21 | /97 ANI | NA POT. | TS. MD. | |
| e funeral director, I. examiner mus | | 21. SIGNATURE OF FUNERAL SERVICE LIC | CENSEE | | | 22. NAME / | ND ADDRESS OF | F FACILITY | | | | |
| fune Exam | ļ | 22. NAME AND ADDRESS OF FACILITY WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401 | | | | | | | | | | |
| d in by the or removal. medical e | | 23. PART I. Enter the diseases, or called the shock, or heart failure. | complications that | caused the | daath. Do ne | ot antar tha m | oda of dying, | such as car | PULIS, | atory arre | et. Approximata | |
| viter this certificate has been signed by the attending physician and completely fille eath with the State Dept. of Health and Mental Hygiene prior to burial, cremation, marked, or item 23 shows any injury, or other traumatic event, the | BY PHYSICIAN: MEDICAL CERTIFICATION | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that infilated eventa resulting in death) LAST PART II. Other significant condition DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNED OF DEATH 1 Netural 5 Pending Investigation | DUE TO (O | Bath but no Bath b | SEQUENCE OF SEQUEN | NO EN CONTROL OF LOCAL IN WIN M 1 | UNCERT | TAIN Dance 8 Other | 24e. WAS AN PERFORI 1 YES 2 or (Specify) SCRIBE HOW IN | JURY OCCU | 24b. WERE AUTOPSY FINONGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| after d | <u>a</u> | 3 Suicide 6 Could not be datarmined | building, at | c. (Specify) | nome, ferm, at | reet, factory, offi | | | CATION (Street ar or Town, State) | nd Number o | r Rural Route Number, | |
| DIRECTOR: hours after item 28 l | | 29a. CERTIFIER | | | | | | | | | | |
| 로 오 = | MPL | (Check only one) 1 CERTIFYING PHYSII ONE) | | | | | | | | | | |
| FUNERAL within 72 TANT: 11 | 8 | 29b. SUCHATURE AND TITLE OF CERTIFIER | | | or investigation | , in my opinion, | _ | | e end piece, and | | | |
| TO THE FUNER be filed within IMPORTANT: | TO BE | Jemy Q. S. | parble, | MD | | | 29c LICENSE | 376 | 7 | ► 0 8 | SIGNED (Month, Day, Year) | |
| | | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE | OF DEATH (I | 1EM 27) (Type, I | LA | | 200 | | | Pasadena | |
| | - | 31. DATE FILED (Month, Day, Year) | 32. REGISTRARY | S SIGNATURE | 0419 | 1341- | imore | -11~ | NAPO | 15/ | MW WD21122 | |
| | | | | | | | | | | | | |
| | | AUG 1 9 1997 | 1.5 | Tail. | . נ מל | | | | • | | | |

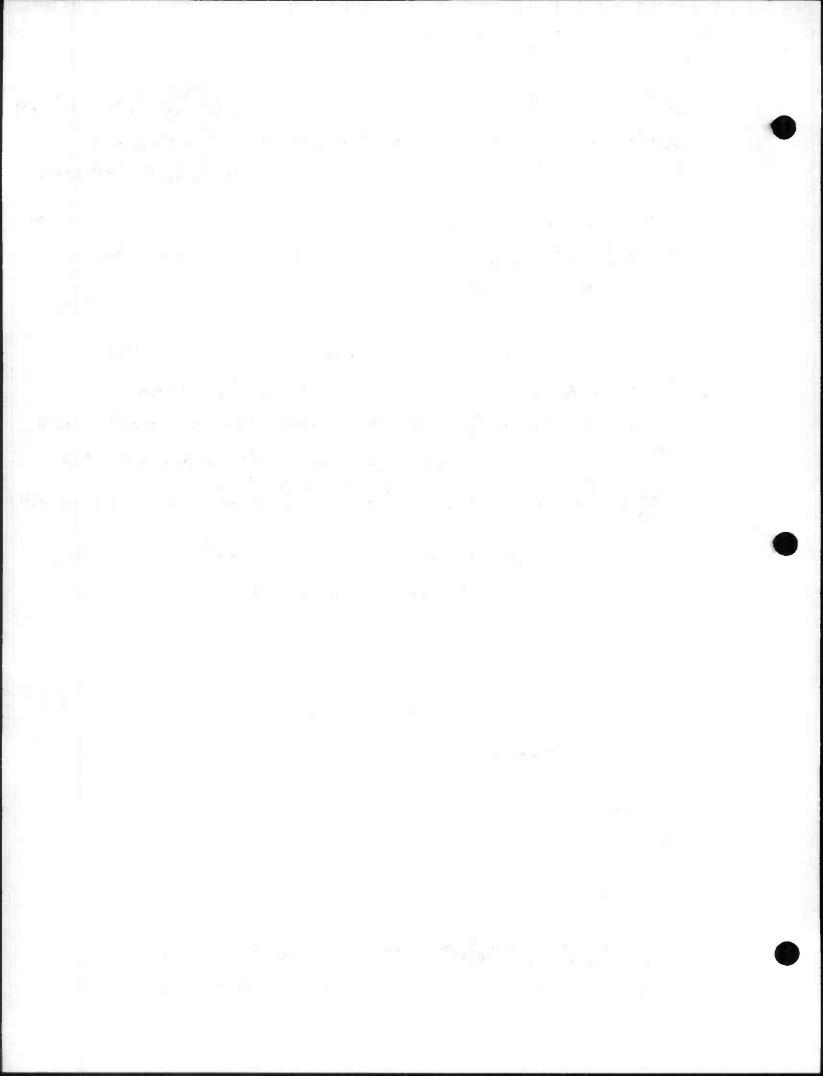
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

2. DATE OF DEATH



State of Maryland / Department of Health and Mental Hygiene 0.7

| | | | | J | (| Certificate of | | Workan riy | Reg. No. | 2 | 1130 |
|------------|--|-------------------|--|---|----------------|---|-----------------------------|----------------------------------|--------------------|-----------------------------|--|
| | Dhualai | | 1. Decedent's Name (First, Middle, La | st) | | | | 2. Deta of De Month | | Veer | 3. Tima of Death |
| | Physici /Medi | | John Jose | ph CRAF | -TON | | | AUG | 15 | 1997 | 9:34 PM |
| 7 | Examir | | 4a. Facility Name (If not Institution, giv | | 1 .1 | | 4b. City, Town, or | Location of Death | | | |
| | | | CARROLL COUR | | _ | ospital | Westmi | nster | | ROL | 4 |
| | Funeral Director | | ヘートノー人のい | ex 2□ F 7. Aga (In | 7 Y | Months Days | | | y. Year) 1928 | 9. Birthpla Count MAH | Aca (State or Foreign |
| | Mend Mend | | Usual Residence of Decedent 10a. State 10b. County | 100 | City, Town | or Location | | | | 10 | d. Inside City Limits |
| | f sh | 0 | md. CADI | 2014 U | 100 | minchen | | | | | 1 ☐ Yes 2 No |
| | 28a | rec | 10e. Street and Number | COLL IN | 16311 | ninster | | | 10a. Citizen of V | Vhat Countr | v? |
| | s 1 end 2 should be filed within 72 hours after death with the Maryland of Health end Mental Hygiene. If Health end Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner risal be notified at | Funeral Director | 3832 Baker | Road | | 211 | 57 | | U.S | A | * |
| | death | Der | 11. Marital Status | 12. Was Decedent Ever i | n U,S. | 13. Was Dacedant of I | Hispanic Origin? (S | specify Yes or No | | e - Amarica | |
| 0 | or ite | | 1 Nevar Married 2 Married | Armed Forces? 1 ☐ Yes 227 No If Yes, Give | | | | to Rican, etc.) | Blac | k, White, et | lc. |
| 215-0020 | ral', c | by | 3 ☐ Widowed 4 ☐ Divorced | Yaar or Dates: | | 1 ☐ Yes 2 🗷 No | Specify: | | Specify | Wh | rite |
| 5-0 | 72 ho | Completed | 15. Decedent's Ed (Specify only highest gre | | 16e. D | ecedent's Usual Occup Give kind of work done ife. DO NOT use retire | pation during most of wo | rkina | 16b. Kind of Bu | isiness/Indu | ustry |
| 121 | ithin Ne. | npl du | Elementery/Secondary (0-12) | College (1-4or 5+) | 7 | | | 9 | 4 | - 1 | |
| 121 | filed within Hygiene. Ither than " | | | 0 | | Sale | | | St | | |
| anc | od off | Be | 17. Father's Name (First, Middle, Last) | / | | | 0 | me (First, Middle, | 4 | | |
| Ĕ | should be nd Mental marked o | To | Charles CR | AFTON | | | Kose | | Uhorn | | |
| Maryland | 12 sho h end l's me traum | | 19e. Informant's Name/Relationship (| Type, Print) | -0 | Mailing Address (Street | _ | | | | |
| | 1 end Health em 27 | 1 | VINA CRAFTO 20a. Method of Disposition | w juite | So: | 32 BAKER | Koad | Westm | | | 21157 |
| ō | | | Burial 2 Cramation 3 | Removal from State | cematery. | crematory or other pla | ice) | -3 / | 20c. Location - | | ni, State |
| Baltimore | | | 4 Donation 5 Other (Specification of Francisco Control of Specification of Francisco Control of Specification of Specificatio | | Dudo | Yark C | em. | 4HMD | Baltim | one, | 11106 |
| Ba | permit. Departr Importa any inju | | 21. Signature of Funeral Service Licer | See / | | 22. Name and Addre | N. Zum | bown F | H | | 1 - |
| | | _ | 1903 Uson | Sumbrun | | 6028 5 | ykesvill | e Rd. | Eldenson | ung-1 | M 21704 |
| | | | 23a Far 1/ Entar the disease, or com- shock, or heert feilure. List only | oligations that caused the d one ceuse on each line. | leath. Do no | t enter the mode of dyl | ng, such as cardia | c or respiratory as | rrest, | | Approximate Interval Between Onset and Death |
| | Physician / Medical | | Immadlate Cause (Final | | | | | | | ' | Oriset and Death |
| | Examiner | | disease or condition resulting in deeth) | · AUUNE | | DOMAR | INM | MUDO | V | - ! | HIS |
| | | ē | | Due t | o (or as a co | nsequence of): | | | | | |
| | of the state of th | Examiner | | b. Brown | ain | The a | who we | Mex Au | MY | i | YRS |
| Ċ, | ifficate be executed g physician end es the bunet-transit | Exa | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due | o (or as a co | nsequence of): | | CH. | SOME | 1 | |
| 68760, | e be sicia | | that initiated events | C. ———————————————————————————————————— | . (05.00.0.00 | nsequanca of): | | | | | |
| | °= 0.0 | 8 | resulting in death) Last | Duali | o (or as a cor | isequarica or). | | | | | |
| Box | eath cert ettendin | 2 | | d | | | | | | - | |
| | death e ette d for | icla | Pert II. Other significant conditions of | ontributing to death but not | resuiting in t | ne undertylna cause ai | van in Part I | 23h Did | obacco use cor | atribute to | the cause of death? |
| P.0 | requires that the death cer seen signed by the ettendir should be detached for use | Physiclan/Medical | | | | | | | | | ably 4 Unknown |
| S, F | es that igned to be deta | by F | NON INSVV | N DOWN |)W/ | DIAGE | 入了 | | | | |
| pro | v require been sig | | 5.2 | | | | | 24a. Was | an autopsy med? | | e autopsy findings lable prior to |
| Record | N 2 50 | plet | | Mensons | | | | perio | (moor | com | plation of causa eath? |
| Ä | The law ate has page 2 | Completed | | | | | | 101 | res 2 No | 10 | Yes 2□ No |
| Vital | | Bec | 25. Was case referred to medical | | | | 26. Piece of Dea | ath (Check only o | ne) | | |
| of V | | To | examinar? 1 Yes 2 No | Hospital: 1 ☐ Inpatient | ETER/Outp | etient 3 DOA Ot | her: 4 Nursing H | loma 5 ☐ Rasio | dence 6 Othe | er (Specify) | |
| 0 4 | | | 27. Manner of Death 1. ☐ Naturel 5 ☐ Pending | 28e. Dete of Injury (Month, Day Year | 28b. Tin | | ry at | 28d. Describe | now Injury occurr | ed | |
| Division | Attending or death. | Certification: | 2 Accident Investigation | | | | Yes 2 □ No | | | | |
| ĭ <u>×</u> | or Attendii after death. Director: A in by the fu | THE I | 3 Sulcide 6 Could not be 4 Homicide determined | 28e. Place of Injury - A building, etc. (Spi | | , street, factory, offica | | 28f. Location (\$ City or Tox | Straet and Numb | er or Rural | Routa Number, |
| | ital o ral Di | Ce | | | | | | | | | |
| | Hosp 4 hou Fune tely fi | edical | Check only 2 Medical Exam | valcian: To the best of my liner: On the basis of exem | knowledge, d | leeth occurred at the ti | me, date and place | and due to the | ceuse(s) and ma | nner as sta | ited. |
| | To the Hospital or Attendity within 24 hours after death. To the Funeral Director: A completely filled in by the funeral and the formula of the f | Med | one) 29b. Signature and title of certifier | and manner stated. | | | | | | | |
| | 5 ± 5 0 | | 250. Signature and title of certifier | 10 | w/a _1 | 29c. Licens | e number | | 29d. Date signed | i (ivionth, D | uy, 1987) |
| | | | I Walle | MUMA | 12 | C Do | 296/4 Memorial | | 8/1 | 6/9 | 7 |
| | - | | 30. Neme end address of person who | | Item 23a) (Ty | rpe, Print) 200 M | lemorial | Ave., We | stminst | er, M | D 21157 |
| | | | 31. Date filed (Month, Day, Year) | 32 Pagietrar's Si | anatura | CMI. | vou c | sernly | 60 | VIL | busp. |
| | Sta Registr | | | 32 Registrar's Si | | 1.11 | | | | | |
| 191 | - riogisti | CIII | AUG 2 5 19 | 11 Jun around | CON PURC | all | | | | | |



JURIUM LANE

72 hours after death with the Maryland

Funeral

Director

mast be n

Pegas 1 and 2 should be filed within 72 hours after daa nent of Health end Mental Hygiene. Int: If item 27 is marked other than "natural", or items may or other traumatic event, its Medical Examiner in

1. Decedent's Nema (First Middle Lest)

Physician /Medical Examiner Examiner

permit. Pegas Department of Important: If it any injury or c

physician and the bunal-transi P.O. Box 68760. 98 USB Division of Vital Records, funaral after death.

Hospital 24 hours

10

To the Hosp within 24 hor To the Fune completely fi

2. Dete of Deeth 3. Time of Death **Physician** Juanita 4:22Am J. Cosner /Medical 4a. Fecility Neme (If not Institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Doctors Community Hospital Lanham Prince Georges 5. Sociel Security Number if Undar 1 Yeer if Under 24 Hrs. 8. Dete of Birth
Jan. 11, 1927 7. Aga (In yrs. lest birthday) 9. Birthplece (Steta or Foreign 1 □ M 2XX Hours West Virginia 234-38-8188 70 Yrs. Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. inside City Limits Maryland Prince George's Lanham 1 Yas 200No Director 10a. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7313 Powhatan Street 20706 United States Funeral 12. Wes Decedent Ever in U,S Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 ☐ Yes ŽQNo If Yes, Give Yaar or Dates: 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: by White 3 ☐ Widowed 4 ☐ Divorced Specify. Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Waitress Fireside Restaurant 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nema (First, Middle, Maiden Sumeme) Be Edward Secrist 2 Justina Layman 19e. Intorment's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Omer O. Cosner (husband) same as #10 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete XX Burial 2 Cremation 3 Removel from State 8/25/1997 4 ☐ Donetion 5 ☐ Other (Specify) Fort Lincoln Cemetery Brentwood, Maryland 21. Signature of Funanci Selvice License 22. Name and Address of Fecility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Md. 20705 Pen'i. Enter the diseese, o complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert teilure. List only one cause on each line. Immediete Ceuse (Finel diseese or condition resulting in death) Acute Revol Failure 48 his. wheter Mellitus Sequantially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet Initiated events resulting in deeth) Lest Physician/Medicai Due to (or es a consequence ot): Pert II. Other stgniftcant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the causa of death? Extensive Right Cerebral Strate Chemispheric) 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by Ischoner Host Discose; Chronic Revol Drsuffuer 24b. Were eutopsy tindings 24e. Wes en eutopsy available prior to completion of cause of deeth? Hypertensia Continuosular Diseose
25. Was case reterred to medical
exeminer? 1 Yes 2 70 1 Yes 26. Plece of Deeth (Check only one) Hospital: 1 Anpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 ☐ Yes 2 ☐ Qo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred 1 Waturel 5 Pending investigetion 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicida 28a. Piece of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et tha time, date end place, and due to the ceuse(s) end menner as steted.
2 Madicat Examiner: On the bests of exemination end/or investigation, in my opinion, deeth occurred et the time, dete and place, and due to the cause(s) end menner steted. (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifian 29c. Licansa number 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 250 Honover Pluy #204 Greenkett, M 20720 Lwatz,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 Certificate of Death

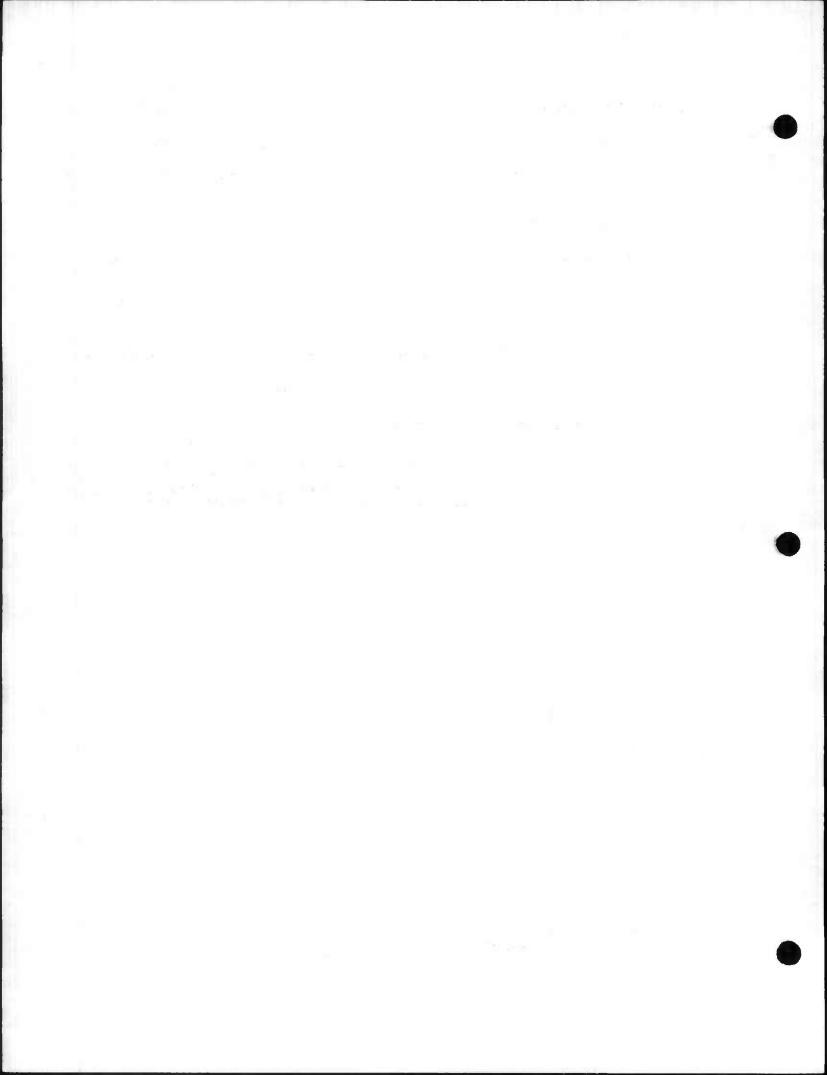
State Registrar

Be



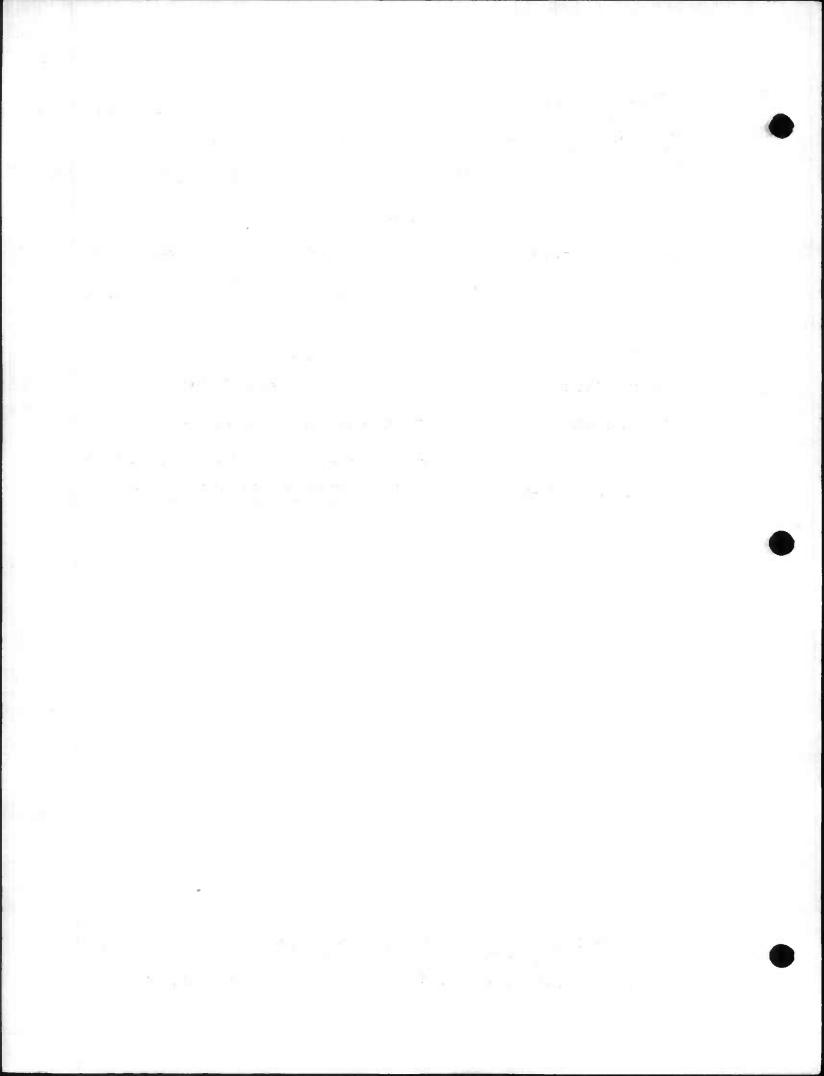
State of Maryland / Department of Health and Mental Hygiene 97 27 132

| | | | | _ | , | Cer | tificate o | | Re | g. No. | 1 2 | 1132 |
|------------|--|------------------|---|---|------------|-----------------------------------|--------------------------------------|---|---|--------------------------------|--------------------------------|-----------------------------------|
| | Physic | an | 1. Decedeni's Neme (First, Middla, La | st) | | | | | 2. Dete of Deet Month | h Dey | Year | 3. Time of Deeth |
| | /Medi | | Marion Joyce Con | Ley | | | | | August 2 | | | 3:07AM |
| | Exami | | 4e. Facility Neme (If not institution, giv | e street and number) | | | | 4b. City, Town, or | | 4c. County | | |
| | | | Shady Grove Adver | ntist Hosp | ital | | | Rockvill | e | Mont | gomery | 7 |
| | Funeral | | Social Security Number 6. 8 | | e (In yrs. | last birthday) | If Under 1 Year Months Day | | 8. Dete of Birth (Month, Day, | | 34 | ce (State or Foreign |
| | Director | | 228-32-9533 Usuel Residence of Decedent | □M ¾CXF | 6 | 7 Yrs. | would buy | Hours Mill. | Nov. 10 | | Virgi | |
| | show | _ | 10e. Stete 10b. County | | 10c. Cit | ty, Town or Loc | eation | | | | 10d | I. Inside City Limits |
| | Ne M | Funeral Director | Maryland Montgome | ry | Be | thesda | T | | | | | 1 ☐ Yes 2 ☐ No |
| | € 9 E | To | 10e. Sireat end Number | | | | 10f. Zip Coda | | 10 | g. Citizen of V | Whel Country | ? |
| | 23a | - a | 9510 Page Avenue | | | | 20814 | | J | United | States | 3 |
| | em . | Tue | 11. Marital Status | 12. Was Decedeni Armad Forcas? | | ,S. 13. W | as Decedent of Yes, specify Cu | Hispanic Origin? (S ben, Mexican, Puart | pecify Yas or No- o Rican, etc.) | | e - Amarican k, Whita, etc | |
| 21215-0020 | s 1 end 2 should be filed within 72 hours efter death with the Meryland I Health and Mental Hyglene. If Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, Ite Medical Examiner must be notified at | þ | 1 Never Married 2 Married 3 🖾 Widowed 4 Divorced | 1 ☐ Yes 2 [X] If Yes, Give Yaer or Detes: | No | | □Yas 2XN | | | Specify | | |
| Ö | 2 ho | Completed | 15. Decedent's Ed | Jucation | | 16e. Decede | ent's Usual Occ | upetion | T · | 6b. Kind of Bu | | |
| 215 | 7 nic 7 | pie | (Spacify only highest gra Elementary/Secondary (0-12) | | | (Giva k life. D | ind of work don O NOT use retii | a during most of wor red) | king | | | |
| 21 | d with | E | Elementary/Secondary (0-12) | College (1-4or 5 |)+) | Journ | alist/H | omemaker | | Radio/ | Own Ho | ome |
| | Hys ent | Bec | 17. Fether's Neme (First, Middle, Last, | | | | | | ne (First, Middle, N | | | |
| Maryland | id be enta ked c ev | ToB | Percy Cooke | | | | | Tuoi11 | e Puller | | | |
| ary. | M by mer | - | 19e. Informant's Name/Reletionship (| Type, Print) | | 19b. Mailing | Address (Stree | et and Number or Ru | | City or Town | State Zio Co | ode) |
| Σ | end 2 saith a n 27 is | | Lucy A. Conley/Da | | | | | enue, Bet | | | | |
| ē, | Health Health Iem 27 | | 20e. Method of Disposition | agniei | 20b. F | Plece of Dispos | ition (Name of | enue, bet | Date 2 | Oc. Location - | City or Town | . 4 1. Stete |
| no | | | 1 Buriel 2 Crametion 3 | | | emetery, crem | atory or other pi | (ace) August | 28, 1997 | | | |
| Baltimore, | it. P | | 4 ☐ Donation 5 ☐ Other (Specification of Funeral Sarvice Licer | | Moi | ntgomer | y Crema | torium, I | nc. | Bethes | da, Ma | aryland eral Home/ |
| Ba | permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: if Item 27 is marked other than any injury or other traumatic event, The MADGE. | | 21. Signature of Full eral Salvice Lices | 12 | 1000 | Be | thesda- | Chevy Cha | se, Inc. | 7557 | Wiscon | rai Home/ isin |
| | | | 23a. Pert1. Entar tha disease, or com shock, or heert feilure. List only | plications that caused | MOO8 | h. Do not ente | r the mode of d | ethesda, | maryland or respiretory erre | 20814 | | pproximeta itervel Betwaen |
| | Physician /Medicai Examiner | | Immediete Cause (Finel disaasa or condition resulting in deeth) | e. Pneum | onia | or és a consequ | - | | | | Ö | nsat end Death |
| | | ē | | | D00 10 (C | n es a consequ | refice of). | | | | | |
| | death certificate be executed e ettending physician and of for use es the bunel-transit | Examiner | Sequentially list conditions | b | Due to (c | or es e consequ | ience off: | | | | | |
| ó | an ar | | Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events | | | | | | | | - | |
| 68760, | te be | Medical | Cause (Diseese or Injury that initiated events resulting In deeth) Lesi | c | Due to (o | ras a consequ | ence of): | | | | - | |
| | ndiffice ng ph es th | Jed | resulting in death) Lesi | | | | | | | | | |
| Вох | eath cer ettendin I for use | an. | | d | | | | | | | | |
| | deal de ett | sici | Pert II. Other significant conditions of | ontributing to death be | ut not res | ulting In the unc | dertying cause g | iven in Pert I. | 23b. Did tol | Dacco use co | ntribute to th | ne cause of death? |
| P.0 | by the de | Physician/ | | | | | | | 1 □ Ye | s 2 No | 3 Probab | bly 4⊠Unknown |
| | es that igned be be det | by F | Gastrointestinal | Bleeding | | | | | | | | 21 |
| Records, | The law requires that the ste has been signed by the page 2 should be deteche | | Damantia | | | | | | 24e. Wes er | | 24b. Were | eutopsy findings able prior to |
| 00 | s bed 2 sho | Completed | Dementia | | | | | | panom | ieur | comp of dee | letion of causa |
| Ä | The law sete hes page 2 | mo | | | | | | | 1□ Ye | s 2√2 No | 1 🗆 Y | |
| Vital | | | 25. Wes case referred to medical | | | | | 00 Diseased Day | | Λ | - 101 | es 2X140 |
| > | | o Be | examiner? | Hospitel: | -1 00 | E0/0 4 | 2000 | ther | th (Check only one | - | | |
| ō | Phys rthis aral di | - | 1 ☐ Yes 2 ☒ No 27. Manner of Death | 1 X Inpatia 28e. Dete of Inju (Month, Da) | | ER/OutpetienI 28b. Time of | 3□ DOA 28c. Inj | 4 Li Nursing n | ome 5 Rasida 28d. Describe ho | | | |
| o | ding th. | tio | 1 Naturel 5 Pending 2 Accident investigation | | Year) | Injury | | onk? ⊒Yes 2 ⊒No | | | | |
| Division | I or Attending effer death. Director: After d in by the fune | Certification: | 3 Suicide 6 Could not be | 28e. Place of Inju | ry - At he | ome, ferm, stre | et, fectory, office | 9 | 28f. Location (Str | | er or Rural R | loute Number, |
| 5 | Dir. | ert | 4 Homicide | building, ef | : (Specif | y) | | | City or Town | State) | | |
| | To the Hospital or A within 24 hours effer To the Funeral Director Completely filled in b | edicai C | 29a. Certifier 1X Certifying Ph (Check only one) 2 Madical Exert | yelclan: To the best of liner: On the basis of and menner ste | examina | wledge, death tion and/or Inve | occurred et the estigation, in my | time, dete end plece oplnion, death occu | , end due to the ca rred at the time, da | use(s) and ma te end place, | nner as state and due to th | ed. e ceuse(s) |
| | of the of | Me | 29b. Signeture and title of certifiar | | | | 29c. Licer | nse number | 29 | d. Deta signe | (Month, Da | y, Year) |
| | 12 | | mal | new | | | - 0.0 | 001 | | | 0.6 | |
| | 1 | | 20 Name and address of account | somelated | nath the | 000) /7: | D33 | ZZ4 | I A | ugust | 26, 19 | 196 |
| | | | 30. Name end address of person who | | | | | 00 1 | | 1 1 | 00050 | |
| | | | | 50 West Ed | | | ive, #3 | UJ, Kockv | ille, Mar | yLand | 20852 | |
| | Sta | te | 31. Dete filed (Month, DAUG2 9 | 1997 | lia Ma | h | orwood. | | | | | |



State of Maryland / Department of Health and Mental Hygiene 97 27133

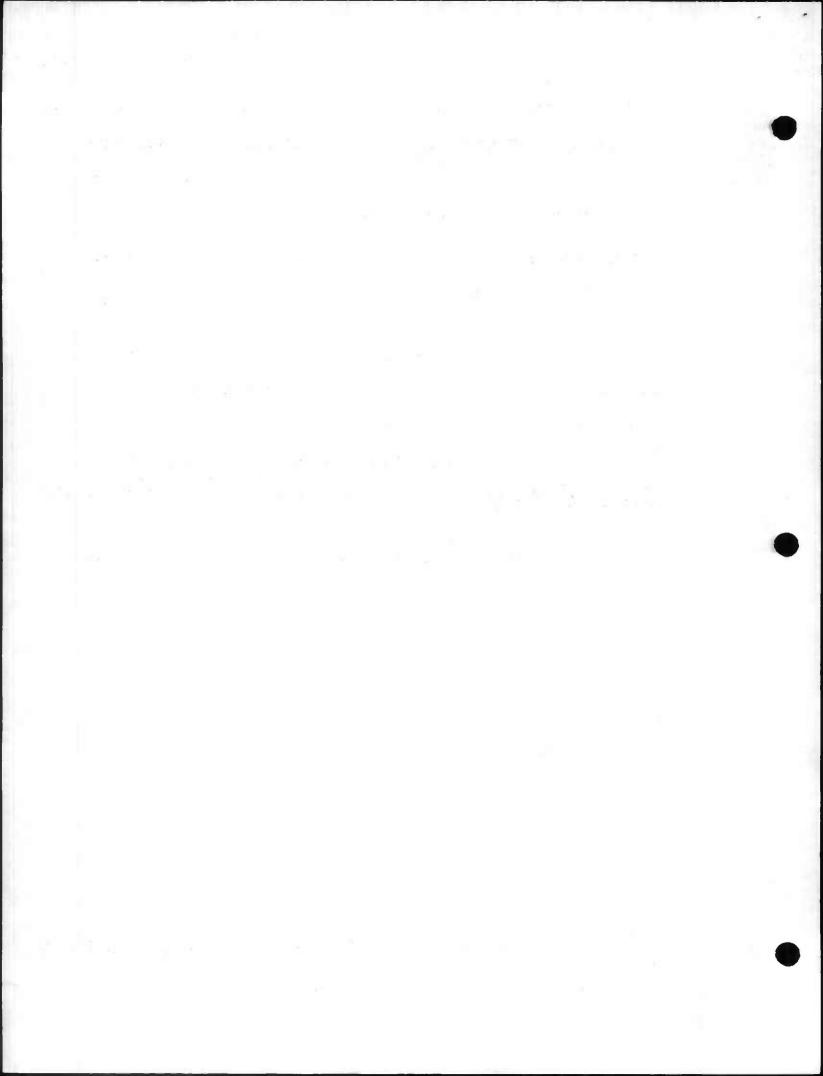
| | | | | Otato of Mary | | Certifica | | | i wichtai i iy | Reg. No. | 1 61 | 133 |
|------------|--|--------------------------|---|--|----------------------------|-----------------------------------|--|---------------------------------------|---|------------------------------------|---|------------------------------|
| | Physic /Medi | | 1. Decedent's Name (First, Middle, Last) | kins | Cole |) | | | 2. Data of De Month | Day 15 | Year 1991 | 9. 02R |
| | Examin Funeral Director | ner | 5. Social Security Number 6. Sax | off Ro | yrs. last bin | | Phy lar 1 Year | b. City, Town, of the Lift Under 24 H | in. (Month, Da | Prin | 9. Birthplace | rge a (Stata or Foreign |
| | and w | | Usual Residence of Decedant 10a. Stata 10b. County | 100 | : City, Towr | or Location | | | оср. | | | Inside City Limits |
| | a-f sho | ctor | DC NA | | Was | hingto | n | | | | | Yas 2□No |
| | ith with the 23a or 28 | Funeral Director | 10e. Street and Number 325 Madison Stree | t, N. W. | | 10f. 2 | Zip Coda 2 | 0011 | | 10g. Citizan of V | What Country | |
| 020 | permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mentel Hyglene. Important: if item 27 is merked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercises must be notified at once. | by | 11. Marital Status 1 □ Navar Married 2 □ Married 3 □ Widowed 45 Divorced | 2. Was Dacedant Evar Armed Forcas? 1 ☐ Yas 2 XNo If Yes, Giva Yaar or Datas: | in U,S. | | edant of Hi becify Cuba 2 XNo | | (Specify Yas or No arto Rican, atc.) | Specify | ce - Amarican I ck, Whita, atc. y: Blac | |
| 21215-0020 | within 72 hc iene. than "netur the Medical | Completed | 15. Decedant's Educ (Specify only highast grade Elementary/Secondery (0-12) 10th | etion completad) Collega (1-4or 5+) | 16a. | | sual Occupa work dona d usa retired USEKE | luring most of v | vorking | 16b. Kind of Bu | usinass/Indust | 774 |
| | el Hyg I other vent, | Be C | 17. Fathar's Nama (First, Middia, Last) | <u> </u> | | | | 18. Mothar's N | lama (First, Middle | , Maidan Suman | | |
| Maryland | d Ment d Ment nerke nerke | To | Charles Atkins | n Christi | 101 | 6 A - W - A - Lale- | (0) | | ine Atki | | | |
| | ofth and 25 is r | | 19a. Informant's Name/Relationship (Ty) Mavis Francis | e, Print) | | | | | Rural Route Numb W., Wash | | | • |
| Baltimore, | Peges 1 and the sufficient of the sufficient of the sufficient suf | | 20a. Mathod of Disposition 120 Burial 2 ☐ Cramation 3 ☐ R. 4 ☐ Donation 5 ☐ Othar (Specify) | amoval from Stata | b. Place of cematar | Disposition (A) y, cramatory of | lama of r othar place | 9) | Date 8/23/97 | 20c. Location - | | , Stata |
| Balt | permit. Departn Imports any inju | | 21. Signature of Funaral Sarvice License | | | R. N. | Hort | | Morticia | | | 0011 |
| | أعدب | | 23a. Part1. Entar the disaasa, or complications, or haart failura. List only on | etions that caused tha caused that cause on each line. | daath. Do n | ot antar tha m | oda of dyln | , such as card | iac or raspiratory a | rrast, | Ap | oproximata tarval Batween |
| P | Physician /Medical Examiner | | Immediata Causa (Final diseasa or condition rasulting in daath) a | | | . Arr | | | | | | Jours |
| | p is | iner | - h | | to (or as a c | Sc/ev | 9: 021 S | | | | Y | PELAS |
| Ć, | execute n end iai-tran | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated avants | | 1 | onsequence o | n: | | | | | lears |
| ox 68760, | The law requires that the death certificete be executed ate hes been signed by the attending physician end page 2 should be deteched for use es the bunat-transit | Medical | Causa (Disaass or Injury that initiated avants rasulting in daath) Last | | evial | onsequance of |): | | | | | 4000 |
| Box | death se atter | siciar | Part II. Other significant conditions cont | ributing to death but not | resulting in | tha undarlying | ceusa give | en in Part I. | 23b. Did | tobacco usa co | ntribute to th | e causs of death? |
| s, P.O. | ss that the death cer gned by the attendin be deteched for use | by Phy | | ndent | | | | | 10 | Yas 2000 | 3 Probab | ly 4□Unknown |
| Records, | e law requires that hes been signed b ge 2 should be det | Completed by Physician/A | Seizure Di | sordeR | | | | | perfo | an autopsy ormed? | availat comple of dea | |
| ital | | Be Co | 25. Was cese rafarred to medical | | | | | 26. Piace of D | eath (Check only) | | 1 🗆 Ya | as 2 No |
| of Vital | physici this cer al direc | ToE | TEL TAS ZINO | ospital: 1 🗆 Inpatiant | 2 ☐ ER/Out | patient 3 🗆 [| | r: 4⊠ Nursing | Homa 5□ Rasi | | ar (Specify) | |
| ouo | After the | tion: | 27. Mannar of Death 1. SNatural 5 ☐ Panding invastigation | 28a. Data of Injury (Month, Day Yea | r) 28b. T | ima of ijury M | 28c. Injury Work | at ? ′as 2 □ No | 28d. Describe | how injury occur | red | |
| Division | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. | Certification: | 2 Accidant invastigation 3 Sulcida 6 Could not be 4 Homicida dataminad | 28a. Place of Injury - / building, atc. (Sp | At homa, far pecify) | | | 22.10 | 28f. Location (City or To | Street and Numb wn, Stata) | oer or Rurai Ro | outa Number, |
| | To the Hospita within 24 hours To the Funeral completely filled | edical | 29e. Certifiar 1 Certifying Physic (Check only one) 1 Medical Examin | clan: To the best of my er: On the basis of exan and manner stated. | knowledga, ninetion and | daath occurre /or invastigatio | d at the tim on, In my op | a, data and pla Inion, daath oc | ce, and dua to tha curred at the tima, | ceusa(s) and ma deta and place, | innar as state and dua to the | d. a ceusa(s) |
| | Toth | M | 29b. Signatura and titla of certiflar | Il. Bir | nis, | MO 2 | 9c. Licanse | number 8 5 9 | 3 | 29d. Data signed | d (Month, Day | ', Year) |
| | , | | 30. Nama and address of person who co | 3-0110 | \ I | | W. | NASH | D-C. | 20010 | 0 | |
| | Sta | | 31. Data filed (Month, Pay Geer) 7 1 | 32. Registrant S | ightfure New (e.s. | n-Handa | E. | 1 | | | | |



State of Maryland / Department of Health and Mental Hygiene 97 27131

| | | | | Certificate of D | Death | Reg. No. | 21104 |
|---------------------|--|---------------------|---|--|---|---|---|
| | Discort | | Decedent's Name (First, Middle, Last) | | 2. Date of D Month | | 3. Time U Death |
| | Physic /Medi | | JONATHAN CHAO | | August | Day Year 24 1997 | 9:46pm |
| 0 | Exami | | 4a. Facility Name (If not institution, give street and number) | 4b | . City, Town, or Location of Dear | th 4c. County of Dee | th |
| | | | SHADY GROVE ADVENTIST HOSPITAL | | ROCKVILLE | MONTGOM | ERY |
| | Funeral Director | | 5. Social Security Number 8. Sex 7. Age (In yrs. last 1 M 2 F 71 Usual Residence of Decedent | t birthday) If Under 1 Year Months Days | Hours Min. 8. Date of Bi (Month, D | rth 9. Bird (Co. 8, 1925 Ch. | thplace (State or Foreign puntry) ina |
| | Maryland f ehow | or | 10a. State 10b. County 10c. City, T | own or Location hersburg | | | 10d. Inside City Limits 1 ☐ Yes 2 🕅 No |
| | with the Mary a or 28e-f eh be notified | rect | 10e. Street and Number | 10f. Zip Code | | 10g. Citizen of What Co | nuntry? |
| | 23a or | Ō | 605 Suffield Drive | 208 | 70 | United S | |
| | ne 23e | era | 11. Marilal Slatus 12. Was Decedent Ever In U.S. | | | | |
| Maryland 21215-0020 | 72 hours after death with the Maryland hashing, or fleme 23a or 28e-f ehow local Examine must be notified at | by Funeral Director | Amed Forcas? 1 ☐ Never Married 2 ☐ Married I ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: | | spanic Orlgin? (Specify Yes or Ni , Mexican, Puerto Rican, etc.) Specify: | | e, etc. sian |
| 20 | n 72 hours "natural", borcal Ex | Completed | 15. Decedent's Education 1 (Specify only highest grade completed) | 6a. Decedent's Usual Occupat | tion | 16b. Kind of Business/ | Industry |
| 2 | C 1 8 | ple | Elementary/Secondary (0-12) College (1-4or 5+) | (Give kind of work done du life. DO NOT use retired) | uring most of working | | |
| 2 | D D N | Con | | Clerk | | Retail | |
| nd | s 1 and 2 should be filed within the filed within the filed by the filed the filed the filed the file filed the filed fi | Be (| 17. Father'a Name (First, Middle, Last) | 1 | 18. Mother's Neme (First, Middle | , Maiden Sumame) | |
| Va S | Ment | 2 | Chung-Kuan Chao | | Chen-Kuan Ch | ang | |
| a | and and | | 19e. Informent's Name/Reletionship (Type, Print) | 19b. Mailing Address (Street ar | nd Number or Rural Route Numb | per, City or Town, State, . | Zip Code) |
| ≥ : | and salth | | Li Hung-Tao Chao | 605 Suffield D | r. Gaithersbur | g,Md. 20878 | |
| Baltimore, | permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tre 2028. | | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State came | e of Disposition (Name of etery, crematory or other place) of Heaven Cem | Aug. Ju | 20c. Location - City or Silver Spr | |
| Balt | permit. Pages Department of Inportant: If the any Injury or of | | 21. Signature of Funeral Service Licensee | 22. Name and Address | of Facility DeVol Fu eer Park Dr. Ga | neral Home | |
| | _ | | 23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart fellure. List only one cause on each line. | Do not enter the mode of dving. | such as cardiac or respiratory a | erresi | Approximate |
| ١. | hysician | | shock, or heert feilure. List only one cause on each line. | | , | | Interval Between Onsel and Deeth |
| | /Medicai Examiner | L | resulting in death) | ular Accident | (Stroke) | | 10 Days |
| x 68760, | cerrificate be axecuted of an organization of the principal and as the burial-transit | Medical Examiner | if any, leading to Immediate cause. Enter Undertying Ceuse (Disease or Injury | a consequence of): | | | |
| O. Box | mat the daath cer ed by the attendin detached for use | Physician/ | Part II. Other significant conditions contributing to death but not resulting | g in the underlying cause giver | n in Part f. 23b. Did | tobacco use contribute | to the cause of death? |
| J | d by | | Pneumonia | | 1 🗆 | Yes 2 No 3□P | robably 4 Unknow |
| Records, | aw requires is been sign 2 should be | Completed by | Urinary Tract Infection | | | ormed? | Were autopsy findings available prior to completion of cause of death? |
| | 0 2 0 | no. | | | 10 | Yes 2 No | 1 ☐ Yes 2 ☐ No |
| | certificata | Be C | 25. Was case referred to medical | | 26. Place of Death (Check only | | |
| of Vital | yalcıi is cer direc | ToB | examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☑ Inpatient 2 ☐ ER/ | /Outpatient 3□ DOA Other | | | cifv) |
| | 五年 百 | | 27. Manner of Deeth 1 □ Natural 5 □ Pending 2 □ Accident Investigation 2 28a. Date of Injury (Month, Day Year) 28l | b. Time of 28c. Injury a Work? | | how injury occurred | 5.97 |
| = ; | rai or Attending after death. | Certification: | 3 ☐ Sulcide 4 ☐ Homlcide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify) | , farm, street, fectory, office | 28f. Location City or To | (Street and Number or Ru wn, State) | ural Route Number, |
| Dan Manne | to the nospital or Attending within 24 with the state death. To the Funeral Director: After completely filled in by the fune | ledical | 29a. Certifier (Check only one) 1 | dge, death occurred at the time and/or Investigetion, in my opin | e, dete end plece, end due to the nion, death occurred at the time, | ceuse(s) and manner es date and placa, and due | s stated. to the ceuse(s) |
| 9 | Tot | Σ | 29b. Signature and title of certifier | 29c. License | number | 29d. Date signed (Mont | |
| | v | | 30. Name and address of person who completed cause of death (Item 23. | | 4546 | August : | 25 1997 |
| | | | Carl I. Schoenberger M.D. 16220 | Frederick Rd. | #213 Gaithers | burg.Md. 20 | 877 |
| | Sta Registr | ite ar | 31. Date filed (Month, PAUG 291997 32. Registrar's Signature | Son-Randall | | and june and | |

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 27135

| 600 | | | | | | Ce | rtificate d | of Death | 7 | | Reg. No. | , , | Cm 1 | 100 | |
|-------------------|---|------------------|---|--|--|-------------------------|--|-------------------------------|-----------------------------|-------------------------------------|-------------------------------------|--|-----------------------------|-----------------|--|
| | Dhusia | ion | 1. Decedent's Name (First, Middla, La | , | 100 | | | | | 2. Deta of D Month | eath Day | Year | 3. Ti | me of Deeth | |
| | Physic /Medi | | KATHLEEN ANN | CANNA | DAY | | | | | AÜĞÜST | r 20°, 19 | 97 | 9 | :50 PM | |
| | Exami | | 4e. Facility Nama (If not institution, giv | a street and numbe | er) | | | 4b. City, T | own, or Loc | ation of Dea | th 4c. Count | y of Death | 1 | | |
| | | | SHADY GROVE ADVENT | TIST HOSP | ITAL | | | ROCK | VILLE | | MONTY | GOMEF | YS | | |
| I | Funeral Director | | 5. Social Security Number 6. S 493-70-6708 | Sex 7 □M 2只F | Aga (In yrs. lesi 40 | t birthday) Yrs. | If Under 1 Ye Months De | | Min. | 8. Dete of Bi (Month, D EC 17 | irth ey, <i>Year)</i> , 1956 | Cou | oplece (S untry) CONS | tete or Foreign | |
| | p . | | Usuel Residence ot Decedent | | | | | | | | | | | | |
| | show | _ | 10a. Steta 10b. County | | 10c. City, T | rown or Lo | ocation | | | | | | | da City Limits | |
| | Ba-f | Director | MARYLAND MONTGOM | ERY | GERM | ANTO | | | | | | | 1 | Yes 2 No | |
| | th with ti | | 10e. Street and Number 20220 SHIPLEY TER | RACE, #20 |)2 | | 10f. Zip Cod 2087 | | | | 10g. Citizen of UNITE | | | | |
| 020 | s 1 and 2 should be filed within 72 hours aftar death with the Maryland f Health and Mental Hygiena. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumstic event, its Medical Examinal must be notified at | by Funeral | 11. Marital Stetus 1 Mover Married 2 Married 3 Widowed 4 Divorced | 12. Wes Deceder Armed Force 1 Yes 2 If Yes, Give Year or Dates | s? No | | Wes Decedent If Yes, specify C 1 ☐ Yes 2 ☐ | | | cify Yes or Nican, atc.) | o- 14. Rad Ble Specif | ce - Ameri eck, Whita, fy: WH | ican India, etc. | en, | |
| 2-0 | 72 ho | ted | 15. Decedent's Ed | lucation | 1 | 16a. Dece | dent's Usuei Oc | cupetion | nd nd | | 16b. Kind of B | lusiness/ir | ndustry | | |
| 21215-0020 | filed within 7 Hygiena. ther than "r | Completed | (Specify only highast gra Elementery/Secondery (0-12) | College (1-4o | r 5+) | life. | kind of work do DO NOT use re | tired) | | 9 | COMPUT | ERS | | | |
| P | Hyd other | BeC | 17. Fether's Neme (First, Middle, Last) | | <u>1</u> | | | 1 | | (First, Middle | a, Maiden Sumer | ne) | | | |
| Maryland | should be and Mental s marked o | To B | KENNETH DAVID C | ANNADAY | | | | ANNA | KAT | HLEEN | BARNES | 3 | | | |
| any | Should N bring | - | 19e. Intorment's Neme/Reletionship (| | | 19b. Meili | ng Address (Str | eet end Numb | per or Rurel | Route Numi | ber, City or Town | , Stete, Zi | ip Code) | | |
| | 1 and 2 Health a em 27 is | | KATHLEEN B. CANNA | DAY, MOTI | HER | 6409 | WYANDO | TTE, KA | ANSAS | CITY, | MISSOUR | ₹I 6 | 4113 | | |
| Baltimore, | | | 20e. Method of Disposition | | 20b. Plec | e of Dispo | osition (Neme or metory or other | plece) | ATT | Dete 2.5 | 20c. Location | - City or T | own, Ste | ite | |
| Ē | Pages net of h int: If its | | 1 🕅 Buriai /2 🗖 Crametion 3 □ 4 □ Doneyon / 5 □ Other (Specifi | (Removel from State) | 6 | | | | | G. 25, | | TA. N | MISS | DURT | |
| alt | pemit. Page Department of Important: If any Injury or once. | | 21. Signeture of Funeral Sarvice Liber | etuniod uneral Sarvice Doens 22. Name end Addrass of Facility DEVOL FUNERAL HOME | | | | | | | | | | | |
| 0 | 88 5 8 | | 1 Ference h | 10 EAST DEER PARK DR., GAITHERSBURG, MD | | | | | | | | | | | |
| | _ | | 23a Part1 Enter the disease, or com shock or heart failure. List only | plications thet caus | ed the deeth. [| | | | | | | | Appro | ximete | |
| | Physician | | and a firm tanded List only | one cause on eecn | line. | | | | | | | I I | | and Death | |
| а | /Medical | | Immediate Cause (Final disaasa or condition | BOWEL | OBSTRU | CTTO | N | | | | | | 3 WE | EKS | |
| | Examiner | | resulting in death) | e. DOWLD | Due to (or es | | | | | | | | | | |
| | ₽ # | ne. | | CARCII | NOSARCO | MA O | F UTERUS | 5 | | | | 1 | | | |
| | certificate be executed ding physician and isa as the burial-transit | Examiner | Sequentially list conditions, | D | Due to (or es | s e consec | quence ot): | | | | | | | | |
| 90, | sian s | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events | • | | | | | | | | 1 | | | |
| 68760, | 9 5 9 | //Medical | thet initieted events resulting in deeth) Lest | G | Dua to (or es | e conseq | quence ot): | | | | | | | | |
| 9 xo | certifica nding phi usa as th | Me | | d | | | | | | | | 1 | | | |
| Bo | ath | lan | | | | | | | | | | i | | | |
| o | that tha death ned by the atte detached for | Physician | Pert II. Other significent conditions of | ontributing to death | but not resultin | ng in the u | nderlying cause | given in Pert | 1. | 23b. Did | tobacco una co | entributa t | to the ca | use of death? | |
| ۵. | that the ed by detail | | | | | | | | | 1 🗆 | Yes 2 No | 3 Pro | bably | 4 Unknow | |
| of Vital Records, | law requires as been sign 2 should be | Completed by | | | | _ | | | | 24e. Wes | s en eutopsy omad? | 6/ | valleble p | | |
| 3ec | has b | npk | | | | | | | | | | | t deeth? | n of causa | |
| H | The I | Co | | | | | | | | 1 🗆 | Yes 2 No | 1 | ☐ Yes | 2□ No | |
| Vita | icien: The certificate rector, pay | Be | 25. Wes case referred to medical exeminar? | 112-6 | | | | | e of Deeth | (Check only | ona) | | | | |
| of | Physician: this certific ral director, | 2 | 1 ☐ Yes 2 ☐ No | Hospitel: 1 ☑ Inpa | | /Outpatier | II 3LI DOA | | | | idence 6 Oth | | ify) | | |
| | D 9 0 | lon: | 27. Menner of Deeth 1 ☑Naturel 5 ☐ Pending | | ley Year) 28 | lb. Time of Injury | | njury et Vork? | | 8d. Describe | how injury occur | red | | | |
| Sic | 1 8 H | cat | 2 ☐ Accident invastigation 3 ☐ Suicide 6 ☐ Could not be | | | | | Yes 2 | | | (0) | | 10 | | |
| Division | i or Attendir safter death. I Director: Af d in by the fu | Certification: | 4 Homicide determined | 286. Piece of I | njury - At home etc. <i>(Specify)</i> | e, term, str | reet, tectory, offi | Ce Ce | 20 | City or To | (Street end Num) wn, Stete) | ber or Hun | al Houte | Number, | |
| | To the Hospital or Atte within 24 hours after de To the Funeral Directo completaly filled in by ti | edical C | 29a. Certifier (Check only one) 1 ☑ Certifying Ph | ysician: To the besiner: On the basis end menner: | of examination | dge, deeth end/or in | n occurred et the vestigetion, in m | time, dete e y opinion, de | nd plece, er eth occurre | nd due to the d at the time, | ceuse(s) end m , date and piece, | anner as a and due t | stated. to the ca | use(s) | |
| | To the vithin 2 To the comple | Me | 29b. Signature and title of certifier | Jild memer : | | | 29c. Lic | ense number | | | 29d. Dete signe | ed (Month. | , Dey. Yo | ear) | |
| | 12 | () | · Stairs | e Ste | ien | > | | 0104 | 41 | | 8/22 | 19 | 7 | | |
| | | | 30. Neme and address of person who | | | | Print) | | | | , | | | | |
| | | | MOISES N. STEREN | V, M.D., | 10215 F | ERNW | OOD RD. | , #405 | BETI | HESDA, | MD 208 | 817 | | | |

DHMH 16 Rav 6/95

State Registrar

The second secon

State of Maryland / Department of Health and Mental Hygiene AMEND# 1 cms 8/19/97 AA Co Health Certificate of Death 1. Decedent's Name (First, Middle Last) CD 20 2. Date of Death 3. Time of Death **Physician** Month Day Year 9, Direnzo Emelia 1997 8:45 pm August /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunrise Assisted Living Severna Park Anne Arundel 5. Social Security Number If Under 1 Yeer | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F Months Days Hours Yrs 153-10-7914 89 Director 1908 June 16, Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at MD 1 ☐ Yes 2 No Director Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? than "natural", or items 23e or the Medical Exernine: must be r 1968 Cambridge Drive USA 21114 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 White 1 ☐ Yes 2X No Specify: à 3[™] Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12+ Bookkeeper Retail 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 5.2 should be f. h and Mental H 7 is marked off Domenick Provvedi Adele Ginliani 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) pormit. Pages 1 and 2 st Department of Health and Important: If Item 27 is m any injury or other traum Donna Graves/Granddaughter 2774 La Castana Dr. Los Angeles, CA 90046 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Aug. 12 1 ☐ Burial 2XI Cremetion 3 ☐ Removal from Stete Metro Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lio 2. Name end Address of Facility Parranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 tease, or conficient on that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, une List by one ceuse on each line. Physician Metastatic Bone Lesions effate Cause (Final /Medical Unknown Primary Malignany

Due to (or es e consequence of):

M. Lahrosis with pancytopenia Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760. 8 desenden 997 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 23b. Did tobacco use contribute to the cause of death? ď. 1 Yes 2 No 3 Probably 4 Unknown y disease, coronary signed b Records, á 24b. Were autopsy lindings available prior to completion of cause of death? Completed 1492, depression 24a. Was en autopsy performed? pain syndrome, osteoarthritis 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical Be 26. Piece of Deeth (Check only one) Assisted Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ii ii 27. Menner of Death 28a. Date of Injury (Month, Dev Year) Certification: 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Fauilit Athan Division 1 Netural 5 Pending death. 1 TYes 2 □ No 2 ☐ Accident Investigation after death Director: / 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours at To the Funeral Di completely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) end manner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and manner steted. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8-11-97 Name and eddress of person who completed cause of death (Item 23e) (Type, Print) Broadre de Mudical Center Arnold MD21012 D. Don MD elaleca

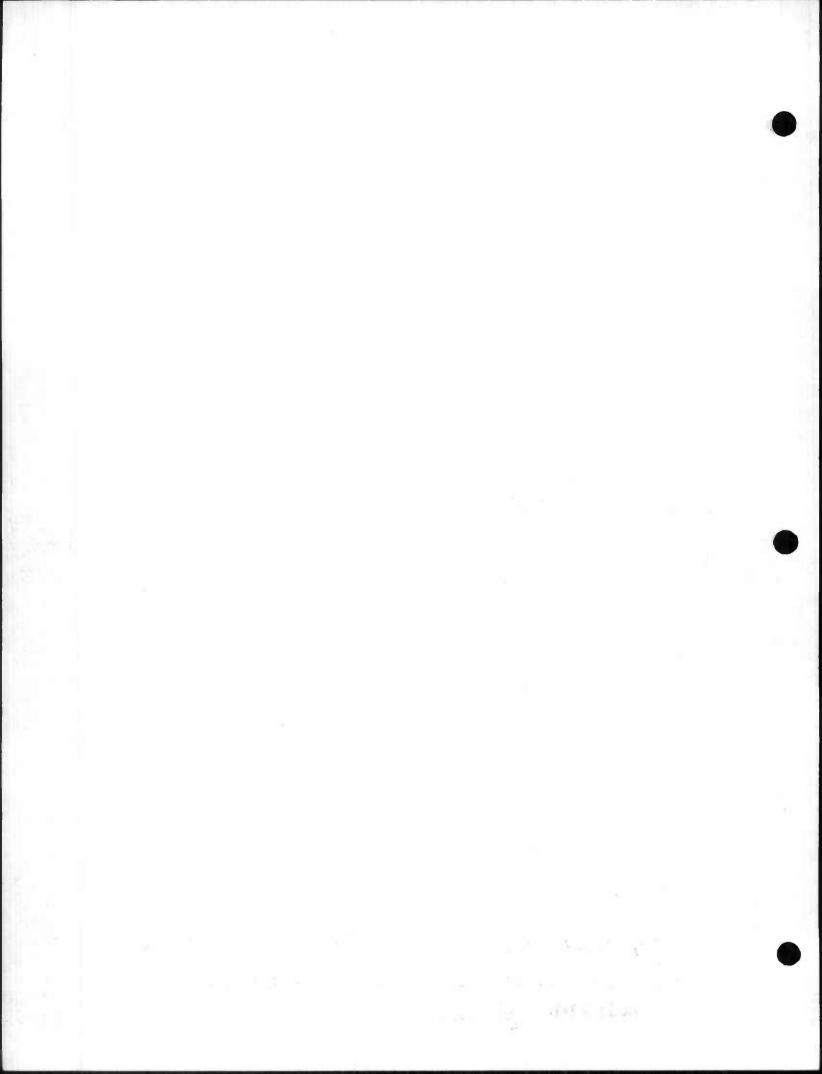
State Registrar 31. Date filed (Month, Day, Yeer)

AUG 1 9 1997

32. Registrar's Signeture

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | | | Cei | rtificate of | Death | | Reg. No. | | |
|--|----------------|---|--|---------------------------------|--|-------------------------------------|---|-----------------------------------|--------------------------|--|
| | | 1. Decedent's Name (First, Middle, La | st) | | | | 2. Date of D | eath | | 3. Time of Death |
| Physic /Med | | Marie Anna | Despeaux | | | | Month | Day | Yeer 1997 | 7:15 p.m. |
| Exami | | 4a. Fecility Neme (If not institution, giv | e street and number) | | | 4b. City, Town | or Location of Dee | | y of Death | |
| | | 207 Old Magot | hy Bridge Road | | | Pasade | | | Anne | Arundel |
| Funeral Director | _ | 5. Social Security Number 6. 8 | Sex 7. Age (In yrs. 81 | | Months Days | | Min. 8. Date of Bi (Month, D Sept 30 | | | place (Stete or Foreign |
| p. | | Usuel Residence of Decedent | | | | | рерс 3 | ,, 1,13 | Mary | yland |
| e Maryla Sa-f shov | ctor | 10a. State 10b. County Anne Aru | | y, Town or Lo sadena | | | | | 19 | 10d. Inside City Limits 1 ☐ Yes 21 No |
| death with the Maryland ms 23a or 28a-f show | al Director | 10e. Street and Number 207 Old Magoth | ny Bridge Road | | 10f. Zip Code | 21122 | | 10g. Citizen of USA | What Cou | ntry? |
| oms er | Funeral | 11. Marital Status | 12. Was Decedent Ever in U, Armed Forces? | S. 13. V | Was Decedent of I Yes, specify Cub | Hispanic Orlgin | ? (Specify Yes or N | | ce - Ameri | cen Indian, |
| thin 72 hours efter dea e. an "naturel", or frems | by | 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | 1 Yes 2 No If Yes, Give Year or Dates: | | I□Yes 2万No | | 2010 / 110011, 010.7 | | y: Wh | |
| n 72 ho | Completed | 15. Decedent's Ed | ducation | 16a. Decad | lenf's Usual Occu kind of work done | pation | working | 18b. Kind of B | iusiness/Ir | ndustry |
| within 72 ene. | du | Elementery/Secondary (0-12) | College (1-4or 5+) | life. E | OO NOT use retire | id) | WOINING | | | |
| DOL | | 17. Fether's Name (First, Middle, Last) | | rey | Punch Op | | Manager 1977 - A. A. A. Cardo | | | g Industry |
| S da b | o Be | Charles Reese | | | | Minn | Neme (First, Middle | , маюн suma genfelde | | |
| 02 9 9 | F | 19a. Informant's Name/Relationship (| Type Print) | 10h Mallin | a Address (Stree | | r Rural Route Numb | | | Codel |
| | | Carol Marie Adk | | | | | idge Road | | | |
| F Healt Hem 2 | | 20a. Method of Disposition | 20b. P | aca of Dispos | sition (Name of | | Date | 20c. Location | | |
| Department of Her important; if them any injury or othe | | 1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify | Metr | o Crem | | | Aug 18 | Bal | timo | re, MD |
| Depa Impo Impo Sany i | | 21. Signature of Puneral Service Vicer 20. Parts Enter the disease, or com eshoot, or heart failure. List drity, | 12 Stom | Ba 49 | 5 Gov. F | Sons, | Highway, | Severna | k Fun | neral home k, MD 21146 Approximate |
| Physician | 1 | | | | | | | | 1 | Interval Between Onset and Deeth |
| /Medical Examiner | | Immediate Cause (Final disease or condition partiting in death) | netasta | alic | Br | rast | Can | cer | (| gue yr. |
| Examiner | 1 | pertiting in death) | | as a conseq | | | | | | 0 |
| B B | li e | _ | ь | | | | | | | |
| be execut ician and burial-tran | I Examine | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or | as a consequ | uence of): | | | | | |
| certificate nding phys | n/Medical | Cause (Disease or injury that initiated events resulting in death) Last | Due to (or | es e consequ | uenca of): | | | | | |
| e death the atte | sicia | Part II. Other significant conditions of | entributing to death but not resu | Iting in the un | deriving cause gi | ven in Part I | 23h. Did | tobacco use co | ontribute t | o the cause of death? |
| 4 20 | Physician/ | 1 | | | donying oddoo g | on arr are i. | | | peth | bebly 4 Unknown |
| v requires been sign should be | Completed by | | | | | | | an autopsy ormed? | av | ere autopsy findings altable prior to impletion of ceuse |
| The lay are has page 2 | dimo | | | | | | | | 40 | death? |
| ician: The tay certificate has rector, page 2 | | 25. Was case referred to medical | | | | | 10 | | 1[| ☐ Yes 2☐ No |
| | o Be | examiner? | Hospitel: 1 Inpatient 2 6 | ER/Outpatient | 3□ DOA ON | 100 | g Home 5 Hesi | _ | | |
| Phys eraid | Ë | 27, Manner of Death | | 28b. Time of | 28c. Inju Wo | 4 LI RUISIN | | how injury occur | | γ) |
| ading and a state of tuner | atio | 1 Matural 5 Pending 2 Accident investigation | | Injury | | rk? Yes 2 □ No | | | | |
| or Attend after death Director: | Certification: | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - At hor building, etc. (Specify, | me, farm, stre | et, fectory, office | | 28f. Location (City or To | | per or Rura | al Route Number, |
| To the Hospital or Attending within 24 hours after destine to the Funeral Director. After completely filled in by the fune | edical C | 29a. Certifier Certifying Phyone) 2 Medical Exam | raician: To the best of my know iner: On the basis of examinati end manner steted. | riedge, death on and/or inve | occurred at the tie estigetion, in my c | me, date and ple pinion, deeth o | ace, end due to the courred at the time, | cause(s) and made dete and place, | anner as s and due to | tated. o the cause(s) |
| Within To the Comp | M | 295. Signature end title of certifier | | | 29c. Licens | | | 29d. Date signe | | |
| | | monk | an | | | | | | | 18,1997 |
| | | 30. Name and address of person who of YUDHISTRA MA | RKAN, M.D. | 1404 | rint) B 5.C | RAIN H | WY. GLE | NBURNI | EM | 0 21061 |
| Sta Registr | | 31. Date filed (Month, Day, Year) AUG 1 9 1997 | 32. Registrar's Signati | ure Aande | e. | | | | | |



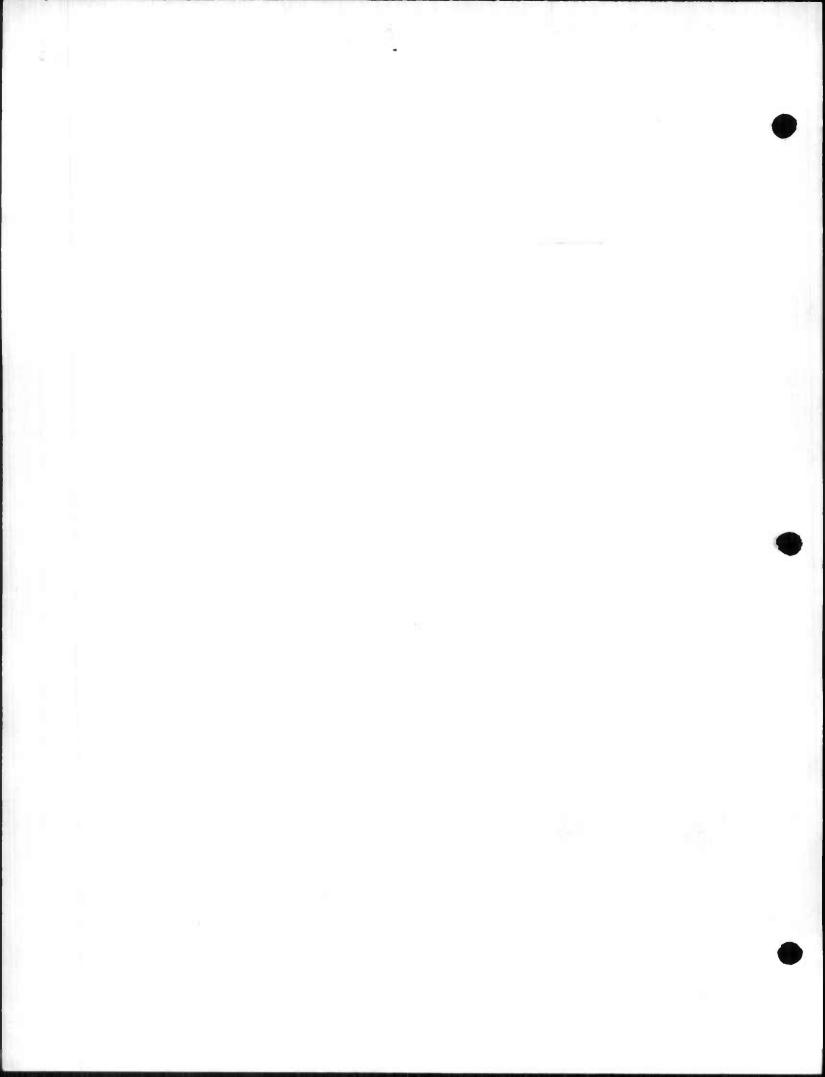
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 27 | 38

| 0 | | | | | | Certifica | te of | Death | | Be | eg. No. | | | |
|------------|---|-----------------|--|---|-------------------------------|------------------------------------|------------------------|------------------------------|------------------------|------------------------------------|----------------------------------|---------------------------|---|---------------|
| | Discontin | | Decedent's Name (First, Middle, Last | st) | | | | | 2 | 2. Date of Deat | h | V | 3. Time of D | Death |
| | Physic /Medi | | Marguerite | Doering | | | | | A | Month August | Day 19 19 | Year 997 | 3:12 | AM |
| | Exami | | 4a. Facility Name (If not institution, give | | | | | 4b. City, Tow | | ation of Death | 4c. County | - | | |
| 1 | | | Ginger Cove | e Health Ca | are Faci | lity | | An | napol | lis | Anne | Arun | de1 | |
| | Funeral | | Social Security Number 6. S | | (In yrs. last birti | Months | r 1 Year Days | If Under 2 | | B. Date of Birth (Month, Day, | Year) | 9. Birthp | iace (State or try) | Foreign |
| | Director | | 215-22-5364 Usual Residence of Decedent | □ M 2X) F | 91 | rs. | Duyo | 110013 | | Jan 19 | | | yland | |
| | how | | 10a. State 10b. County | | 10c. City, Town | or Location | | | | | | 1 | 0d. Inside City | Limits |
| | e Ma | Director | MD Anne An | rundel | | Annapo | lis | | | | | | 1 ☐ Yes | X □ No |
| | or 26 | Sire | 10e. Street and Number | | | | Code | | | 10 | Og. Citizen of V | Vhat Coun | try? | |
| | 15 W | a | 7103 River Creso | cent Drive | | | | 21401 | | | United | Sta | tes | |
| | ter death with the Marylan items 23a or 28a-f show net mant be notified at | Funeral | 11. Marital Status | 12. Was Decedent E Armed Forces? | ver in U,S. | 13. Was Dece If Yes, spe | dent of | Hispanic Origi | in? (Speci | fy Yes or No- | | e - Americ | | |
| 21215-0020 | n 72 hours after death with the Maryland "natural", or items 23s or 28s-f show sorcal Evanther man be notified at | by | 1 Never Married 2 Married 3√Widowed 4 Divorced | 1 ☐ Yes 2X N If Yes, Give Year or Dates: | 0 | 1 ☐ Yes | | | 1 0010 111 | oan, 6to.) | Specify | k, White, Wh | ite | |
| 0 | 2 ho | Pe | 15. Decedent's Ed | | 16a. | Decedent's Usu | al Occu | pation | | T. | 16b. Kind of Bu | usiness/Inc | lustry | |
| 218 | c | Completed | (Specify only highest gra- | de completed) College (1-4or 5- | | (Give kind of wo life. DO NOT u | ork done ise retire | during most od) | of working | | | | - | |
| 21 | T3 Ph - | P.O. | 8 | | | Home | emak | er | | | Ноп | ie | | |
| Maryland | al Hygie I other | Be (| 17. Father's Name (First, Middle, Last) | | | | | 18. Mother | 'a Neme (i | First, Middle, N | faiden Surnam | e) | | |
| yla | should be nd Mantal marked o | To | Robert Flannery | | | | | | Ann | a Dogge | e | | | |
| lan | 2 sho end is m | | 19a. informant's Name/Relationship (7 | Type, Print (Great | 196. | Mailing Addres | s (Stree | t and Number | or Rural I | Route Number, | City or Town, | State, Zip | Code) | |
| | TT TT | | Magdalene C. Flan | nery (Great | Niece) | 997 Rd | und | Bay Ro | oad | Crowns | ville, | Mary: | Land 2 | 1032 |
| ore | of Had | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ | | 20b. Place of | Disposition (Na | me of | | | | 20c. Location - | | | |
| Ē | Pages nent of I ant: If ite ury or of | | 4 □ Donation 5 □ Other (Specify | | Ft. Lin | coln Cr | ema | tory A | ugl 2 | 1, 199 | 7 Brent | wood | Maryla | and |
| Baltimore, | permit. Pages Department of Important: If it any Injury or o | | 21. Signature of Fund Service Licens | 10 | 7 | 22. Name a | nd Addr | ess of Facility | ohn M | i. Taylo | or Fune | ral | Home,] | Inc. |
| | | Н | 23a. Part1. Enter the disease, or comp | plications that caused t | the death. Do no | ATI DO | INC I | OT GIO | ucest | er or. | Annapo | lis, | MD2140 Approximate |)1 |
| | Physician /Medical Examiner |)r | shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) | a. CA | Due to (or es a ci | ma operación of) | | | | | | | Interval Betwee | |
| 68760, | thet the death certificate be axecuted of by the attending physician and detached for use as the bunel-transit | edical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last | c | Oue to (or as a co | | | | | | | | 200 | |
| × | certification of the second | 3 | L L | d | | | | | | | | | | |
| Bo | atten for u | clar | | | | | | | | | | 1 | | |
| 0 | the dr | Physician | Part II. Other significant conditions co | ntributing to death but | not resulting In | the underlying o | ause gi | ven in Pert I. | | 23b. Did tol | bacco use cor | tribute to | the cause of | death? |
| ۵. | as thet igned by be deta | | | | | | | | | 1□ Ye | 2 2 200 | 3 Prob | ably 4 □ Ui | nknown |
| Records, | requir | Completed by | | | | | | | | 24a. Was ar perform | | ava | re autopsy fin- ilable prior to apletion of cau | |
| ě | 9 8 0 | d L | | | | | | | | | _ | | leath? | |
| | cate | | | | | | | | _ | 1 🗆 Ye | s 25 No | 10 | Yes N | 0 |
| = | Physician: The rule centificate rail director, page | Be | 25. Was case referred to medical examiner? | Hospital: | | | 0.1 | | of Death (| Check only one | 9) | | | |
| ō | Phys this ral dii | 7 | 1 Yes No | 1 Li Inpatieni | | | JA | | Ing Home | | nca 8 DOthe | |) | |
| Z : | Ing Afte | ation | Naturei 5 Pending Investigation | 28a. Dete of Injury (Month, Day | Year) 28b. Tir | ne or ury M | 28c. Inju Wo 1 □ | ryat rk? Yes 2∐No | | d. Describe ho | w Injury occurr | ed | | |
| DIVI | Diagra | Certification: | 3 Suicide 6 Could not be determined | 28e. Pleca of Injur building, etc. | y - At home, fam (Specify) | n, street, factor | y, offica | | 281 | Location (Str. City or Town, | eet and Numbe State) | er or Rural | Route Numbe | 91, |
| | To the Hospita within 24 hours To the Funeral completely filled | Medical | 29a. Certifier (Check only one) 1 Certifying Phy C Medicat Exami | sician: To the best of iner: On the basis of e and manner state | xammation end/ | death occurred or investigation | at the ti | me, date and popinion, death | place, and occurred | d due to the ca et the time, de | use(s) and ma te and plece, a | nner as sta and due to | ited. the cause(a) | |
| | Vithir To th | M | 29b. Signature end title of certifier | 1 | | 290 | . Licens | se number | | 29 | d. Date signed | (Month, E | lay, Year) | |
| | | | 1 Mich | all | | 100 | Ι | 24768 | | P | August | 20. 1 | 997 | |
| , | | - | 30. Name and address of person who co | ompleted cause of dea | ith (ttem 23a) (T | vpe, Print) | | - | | | | , | | |
| | | | William A. Dabb | • | , , , | | 110 / | nn and 1 | ie | MD 21/40 | 1 (410 | -22/ | 0070) | |
| | Sta | e | 31. Dete filed (Month, Day, Year) | 32. Registrar | 's Signature | y Aven | uc r | minapo I | .10, | m 414(| 1 (410 | 224- | 00/01 | |

5 (organización se se se

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached within 72 hours after death with the State Deot, of Health and Mental Hydiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
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| AL C | 2 10 | MPORTANT: If Item |
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| 置 | THE | PO |
| 2 | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fined within 72 hours after death with the State Delot, of Health and Mental Hydiene prior to burial, cremation, or removal. | E |

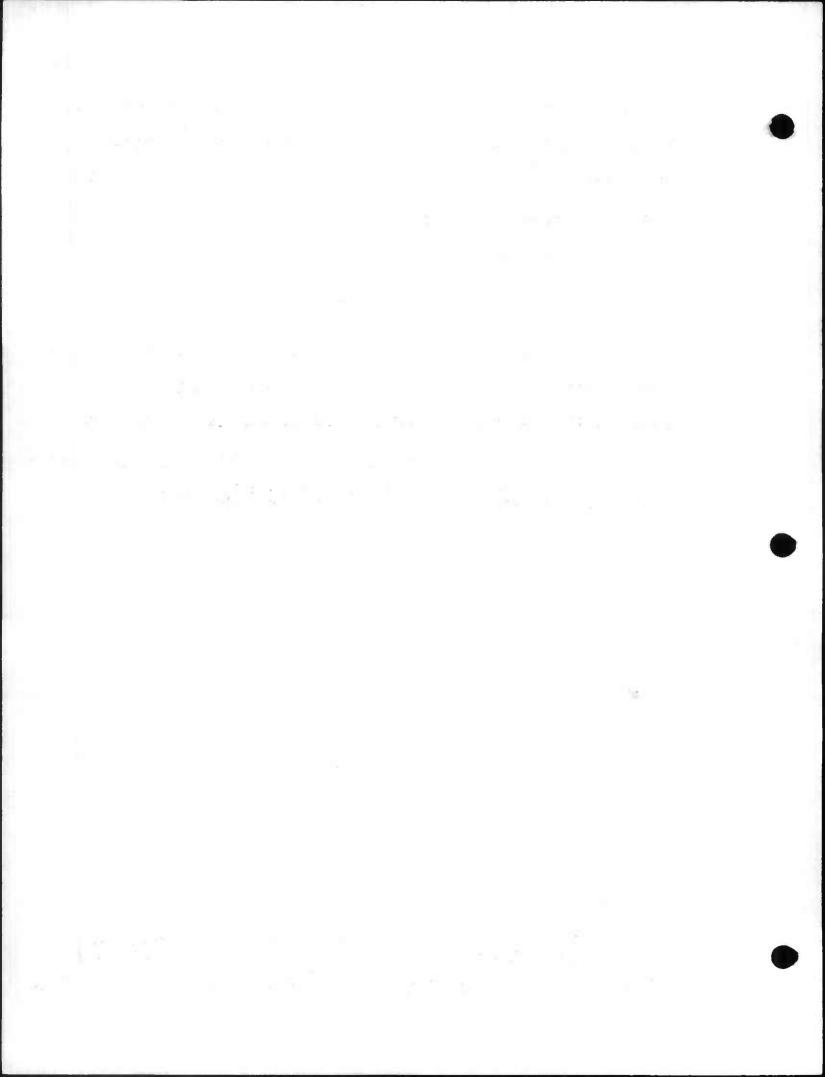
| | FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPAR | | | | | MENTAL | REG. NO. | | | | |
|--------------------|--|---|--|-----------------------------------|------------|----------------------------------|----------|---|---------------------------------|---------------|----------|---|---|
| | DECEDENT'S NAME (First, Middle, Last) T. a. | eonard Dren | | | | | | MONTH | OF DEATH | | EAR | TIME OF DEATH | |
| | 4. SOCIAL SECURITY NUMBER | | (In yrs. lest birthday) | IF UNDER | 1 YEAR | IF UNDER 2 | 4 HRS. | Aug 7. DATE | 26 OF BIRTH | | | ACE (State or Foreign | |
| | 217-26-3132 | 1 N 2 F | 78 YRS. | MONTHS | DAYS | HOURS | MIN. | | /1919 | | Country) | inois | |
| | Se. FACILITY NAME (If not institution, give | street end number) | 70 | 9b. CITY, | TOWN O | R LOCATION | N OF DE | | 71919 | 9c. COUNTY | | | |
| DIRECTOR | Madonna Herita | ige | | Ja | rre | ttsv | i11 | e | | Har | for | đ | |
| E I | 10e. STATE 10b. COUNT | TY | 10c. CIT | Y, TOWN O | R LOCAT | ION | | | | | 1 | Od. INSIDE CITY | _ |
| 8 | Md. Har | Baltimore | 1 | lonkt | ton | | | | | | 1 | LIMITS? | |
| | 10e. STREET AND NUMBER | | | | 101 | ZIP CODE | | | | 10g. CITIZEN | OF WH | AT COUNTRY? | _ |
| E | 3906 Hes | s Road | | | | 211 | וו | | | 11 | s. | Δ | |
| BY FUNERAL | 11. MARITAL STATUS 1 Never Married 2 Married 3X Widowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 X YES IF YES, GIVE WAR OR I | DATES | 1 | f yes, sp | ENDENT OF city Cuben, 2 NO | , Mexica | n, Puerto F | l? (Specify Yea Rican, etc.) | | RACE - | - American Indian, White, stc. | |
| 9 | 15. DECEDENT'S ED (Specify only highest grad | UCATION le completed) | 16e. DECEDENT'S (Give kind of life. Do NOT u | work done o | CCUPATIO | N st of working | , | 16b. | . KIND OF BUS | INESS/INDUST | TRY | | _ |
| COMPLET | Elementary/Secondary (0-12) | College (1-4 or 5+) | Engir | | | | | 7 | Aircra | f+ | | | |
| S | 17. FATHER'S NAME (First, Middle, Last) | | I. Diigii | 1001 | | 16. MOTH | ER'S NAI | _ | Middle, Meiden S | | _ | | - |
| | | Drennan, | Sr. | | | Mai | | | | cher | | | |
| BE | 19a, INFORMANT'S NAME (Type/Print) | , | - | 3 ADDRESS | (Street e | | _ | Poute Numb | ber, City or Town | | de) | | - |
| 2 | I. John Drenna | / | 390 |)6 He | 288 | Rd | M | onkt | on, M | 51 | 211 | 11 | |
| | 20e, METHOD OF DISPOSITION | 20 | b. PLACE OF DISPO | | | | | OHING | | CATION — City | | | - |
| | 1 Buriel 2 Cremetion 3 Rer 4 Donation 5 Other (Specify) | noval from State | other place) | arro | 110 | Crer | nat | ion | Ham | nste | 5.6 | МА | |
| | 21. SIGNATURE OF FUNERAL SERVICE L | ICENSEE | | | | D ADDRESS | | CILITY | | | | , Md.210 | 0 |
| | > Benjamin 1 | V. Kinty | | | | | | & Sc | on, P. | A. F. | н. | P.O.Box | |
| | 23. PART I. Enter disesses, or shock or heart feilure IMMEDIATE CAUSE (Final disesse or condition resulting in death) | e. FACIAL | sech line. | ioma | the mo | de of dyin | ng, suci | h ss cerc | disc or respir | atory srrest | • | Approximate Interval Batweer Onset and Dasti | h |
| CERTIFICATION | Sequentielly list conditions, if any, isacing to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | c | A CONSEQUENCE O | | | | | | | | | | |
| - | PART II. Other significent condition | one contributing to death | but not reculting | in the un | dadula | | luna in | Don't I | 24a, WAS AN | ALTTOROV. | 1 000 0 | VERE AUTOPSY FINDINGS | |
| PHYSICIAN: MEDICAL | | The Continuous to deem | | | idenyin | y cadse y | | | PERFOR | MED? | 0 | MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO | |
| A | 25. WAS CASE REFERRED TO MEDICAL | | | | 26. PI | ACE OF DE | ATH (Ch | eck only or | 20) | | | | _ |
| 泛 | EXAMINER? | HOSPITAL: 1 Inpatient 2 ER/Our | tostlant 3 🗆 DOA | OTHER | 1 : | e 5 🗆 Res | | 1 | | er ker. | 11.0 | C - 1 | |
| Ξ | 27. MANNER OF DEATH | 26s. DATE OF INJURY | 28b. TH | WE OF | 26c. INJ | URY AT | HOWINGE | _ | SCRIBE HOW IN | SSISTED | | y Councilty | - |
| | 1 Netural 6 Pending | (Month, Day, Year) | IN IN | JURY | | PRK? | NO | | | | | | |
| ED BY | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined | 26e, PLACE OF INJUR | Y — At home, farm, ecity) | me, ferm, street, fectory, office | | | | 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. CERTIFIER A CERTIFUNG BUY | SICIAN. To the heat of my loss | | | | | | | 44. | | _ | | - |
| COMPLETED | 29s. CERTIFIER (Check only one) 1 CERTIFIER (Check only one) 1 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated. 2 MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | |
| ш | 29b, SIGNATURE AND TITLE OF CESTEFS | ill A | | | | 29c. LICE | NSE NUR | ABER | | 29d, DATE S | GNED (| Month, Day, Year) | |
| 10 8 | Govert Mule | areghold | | | | 033 | SOLI | | | > 8 | 126 | 147 | |
| - | | 30. NAME AND ADDRESS OF PERSON WHO COMPLITED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIG | NATURE | | | , | | | i | | | | _ |
| | AUG 2 7 1997 | The of Revelor | w Karlall | | | | | | | | | | |



State of Maryland / Department of Health and Mental Hygiene 0.7

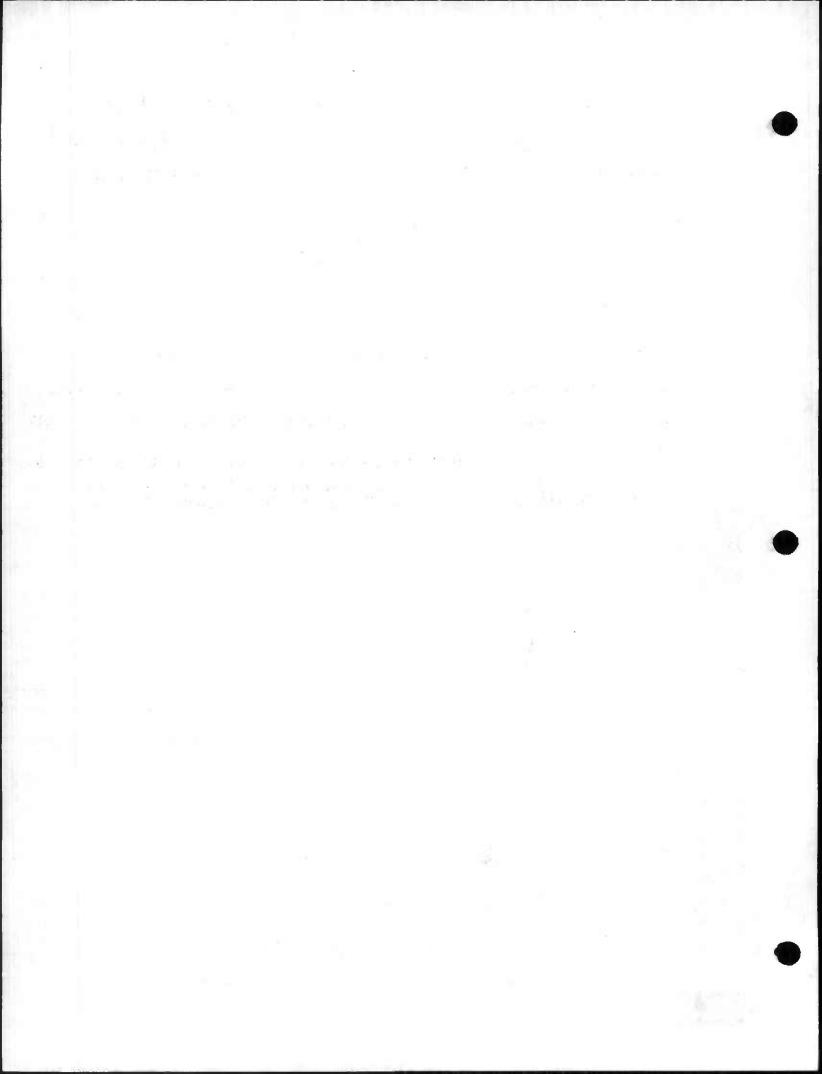
| | | | | | | | rtificate | | Death | | Reg. No. | 1 6 | . / 140 |
|---------------------|---|-----------------------|--|---|-------------------------------|--|------------------------------|------------------|---|------------------------------------|----------------------------------|-------------------------------------|--|
| | Physic | an | Decedent's Name (First, Middle, La | | | | | | | 2. Dete of Do | Day | 997 | 3. Time Death |
| | /Medi | | 2 | arco | | | | | | August | | | 10:20 p.m. |
| 7 | Exami | ner | 4e. Facility Name (If not Institution, given 415 North Stokes | and the same of the same |) | | | 1 | b. City, Town, or L Havre d | | | y of Deeth ford | |
| | Funeral Director | | 218-07-6028 | Sex XXM 2□F | ge (In yrs. la 79 | est birthday) Yrs. | If Under Months | 1 Year Days | If Under 24 Hrs. Hours Min. | 8. Dete of Bi (Month D April | 2, 1918 | 9. Birth Cou Mary | plece (State or Foreign ntry) Land |
| | and w | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, | Town or Lo | cation | | | | | 1 | 10d. Inside City Limits |
| | Many H sh | tor | Maryland Har | ford | F | lavre | de Gr | ace | | | | | 12 Ves 2 □ No |
| | th with the Marylan 23a or 28a-f show | Funeral Director | 10e. Street and Number 415 North Stokes | Street | | | 10f. Zip (| Code 1078 | 3 | | 10g. Citizen of U.S | | ntry? |
| Maryland 21215-0020 | after dea or itema | by | 11. Marital Status 1 Never Merried 2 Married 3 Twildowed 4 Divorced | 12. Was Decedent Armed Forces' 1 Yes 2 If Yes, Give Year or Dates: | ? | | Was Decede f Yes, speci | | ispanic Origin? (Sp n, Mexican, Puerto Specify: | ecify Yes or No Rican, etc.) | | ce - Ameri ck, White, fy: Whi | |
| 5-0 | 72 hours "natural", | Completed | 15. Decedent's E (Specify only highest gro | ducation ade compieted) | | 18e. Deced | dent's Usuel kind of work | l Occup | ation during most of work | ing | 16b. Kind of B | Business/In | dustry |
| 121 | s within 72 h jiene. r than "natu the Modica | dE | Elementary/Secondary (0-12) | College (1-4or | 5+) | | ine O | | | | DA Dail | road- | -Con Rail |
| d 2 | be filed withintal Hygiene. | ပိ | 17. Fether's Name (First, Middle, Last | | | Paci | ine o | ber | 18. Mother's Nam | e (First Middle | | | -COIT NATI |
| an | d be ental | Be O | Adam DiMarco | , | | | | | | a Acoce | | | |
| ary | d 2 should be filed th and Mental Hygi 7 is marked other treumatic event, it | 2 | 19a. Informent's Name/Relationship | Type, Print) | | 19b. Mallir | ng Address | (Street | and Number or Rui | | | , State, Zij | p Code) |
| | and 2 selth a n 27 is | | Virginia Cullum | (Daughter |) | 159 | E. De | en A | Ave., Abe | rdeen, | Marylan | d 21 | 1001 |
| Baltimore, | permit. Peges 1 and 2 Department of Heelth a Important: If hem 27 is any injury or other trat once. | | 20a. Method of Disposition 20a Department of Disposition 4 Donation 5 Other (Special Control of Disposition Disp | | CO | ace of Dispo metery, cren Vary M | netory or of | her pied | e) 8 Cemetery | /28/97 | 20c. Location | | own, State , Maryland |
| Balti | permit. Departmimportal | | 21. Signature of Funeral Service Lice | | = 27. | Ta | Name and | Addre | ss of Fecility ago Funer | al Home | P.A. | | 1 |
| | _ | | 23a. Part1. Enter the disease, or comshock, or heart failure. List only | plications that cause | the death. | | | | Maryland g, such as cardiac | 21001 - or respiratory | | | Approximata |
| | Physician /Medical Examiner | er. | Immediate Cause (Final disease or condition resulting in death) | e. Co | rals | twe es e conseq | hea | A | -00 | ue du | | 1 | Interval Between Onset and Death |
| (68760, | ntificata be executed ng physician and a as the burial-transit | Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest | b | | as a consequence of the conseque | | W | all | all | | | |
| Box | attending for use a | lan/ | | d | | | | | | | | | |
| P.O. | that the de ad by the detached | by Physician/N | Part II. Other significant conditions of | contributing to death to | out not resul | ting in the u | nderlying ca | use glv | en In Part I. | | tobacco use co Yes 2□ No | | to the cause of death? |
| Vital Records, | requires (| Completed by | - Or 1/0 - V | | | | | | | 24a. Was | s an autopsy ormed? | 6/ | /ere autopsy findings vallable prior to ompletion of cause deeth? |
| E B | | 0 | | | | | | | | 10 | Yes 2000 | 1 | ☐ Yes 2☐ No |
| /ita | ysician: s certific director, | Be | 25. Wes case referred to medical examiner? | n en al a | | | | 120 | 26. Place of Deal | h (Check only | one) | | |
| | Physician: rthis certific rral director, | 5 | 1 Yes 20 No | Hospital: 1 ☐ Inpati | | R/Outpatien | | | 4 LI Nursing Ho | | Idence 6 Ot | | fy) |
| L _C | After fune | lon | 27. Manner of Deeth Netural 5 Pending Provident Investigatio | 28a. Date of Inju (Month, Da | y Year) | 28b. Time of Injury | M 28 | Bc. Injur Wor | / at <br Yes 2 □ No | 28d. Describe | how injury occu | rred | |
| Division of | or Attending effer deeth. Director: After | ertifical | 2 Accident Investigation 3 Sulcide 6 Could not be determined | e 28e. Place of In | jury - At hon c. (Specify) | ne, farm, str | | | 165 2 160 | 28f. Location City or To | (Street and Num wn, State) | ber or Run | al Route Number, |
| _ | To the Hospital or Attending within 24 hospital offer deeth. To the Funeral Director: After completely filled in by the fune | edical Certification: | 29e. Certifler (Check only one) 1 Certifying Ph | ysician: To the best ninar: On the besis o end manner st | f examination | ledge, death on and/or inv | occurred a restigation, | it the tin | ne, date and place, pinion, death occur | and due to the red at the time | cause(s) and m date and place | anner as a , and due t | stated. to the cause(s) |
| | To the vithing of the tenth of | M | 29b. Signature end title of certification | w) | | | 29c. | License 3 | number (7(L | | 29d. Dete eign | ed (Month) | Dey, Year) |
| | 10 | | 30. Name and address of person who CULLUS ECL | - JU | 49 | W.C | Print) | 10 | L AUE | ABE | ROPH | UN | D 2001 |
| | Sta Registr | | 31. Date filed (Month, Day, Year) AUG 2 7 1997 | 22. Regist | ar's Signatu | Cardall | | | | | | | |

DHMH 16 Rev 6/95



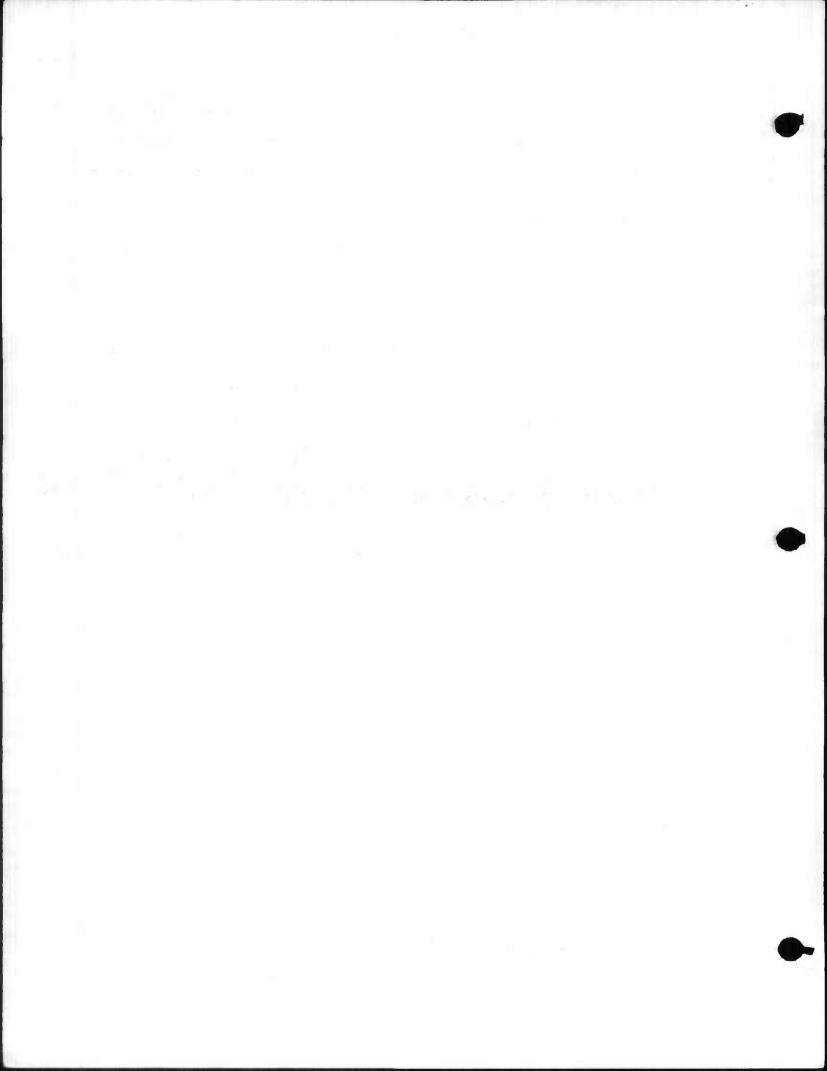
State of Maryland / Department of Health and Mental Hygiene 97

| | | | | | , | Certifica | ate of D | | Mornar 11y | Reg. No. | 1 2 | /141 |
|-------------------|--|------------------|--|--|---------------------|--|-----------------------------------|-----------------------------------|---|--------------------------------------|--------------------------------|--------------------------------------|
| | | 1 | 1. Decedant's Name (First, Middle, Lesi | ") | 2 | | | | 2. Data of De | ath | Vess | 3. Time of Death |
| | Physici /Medi | | Pleanore | MARIE | DI | Ker | SOF | | Month OS | Day 21 | 197 | 1:358 |
| 1 | Examir | | 4e. Fecility Neme (If not Institution, give | street end number) | | | 4b. | City, Town, or | Location of Death | 4c. County | of Deeth_ | . 0 |
| L | Sup u | | Wiger K | MURS | de | , | | Bel | camp | tty | 254 | psa |
| | Funeral Director | | 5. Social Security Number 6. Sa 217-26-2557 Usual Rasidanca of Dacadent | 75-7- | (In yrs. last t | Yrs. Month | | If Undar 24 Hrs. Hours Min. | 8. Dete of Bir (Month, De Dec. 13 | y, Year) 3, 1909 | 9. Birthple Countr Mary. | ece (Steta or Foreign ry) land |
| | yew # | | 10a. State 10b. County | | 10c. City, To | wn or Location | | | | | 10 | d. Inside City Limits |
| | Mary First | ō | Maryland Harfor | rd | | Belcamp | | | | | | 1 ☐ Yes 2½ No |
| | or 284 | irec | 10e. Street end Number | | | - | Zip Code | | | 10g. Citizen of V | Vhat Countr | γ? |
| | th wil | ai | 1123 Belcamp Road | i. | | | 2101 | 17 | | US | A | |
| 0 | permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylend Department of Heelth and Mentel Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any folury or other traumatic event, the Medical Examiner must be notified at any folury. | Funeral Director | 11. Meritel Stetus 1 Never Married 2 Married | 12. Was Dacedent E Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give | | | cedent of Hisp pecify Cuban, | | pecify Yas or No o Rican, etc.) | | e - Amarica ck, White, et | |
| 202 | ral. | i by | 3 ☐ Widowed 4XD Divorcad | Yaer or Dates: | | ILI Tes | 243 NO 3 | Specify: | | Specify | Whi | te |
| 21215-0020 | 72 h | Completed | 15. Decedant's Edu (Specify only highast gred | ication le completed) | 16 | a. Decedant's Us (Give kind of s | sual Occupation | on ring most of wor | rking | 16b. Kind of Bu | isiness/Indu | istry |
| 12 | within ane. than | mp | Elamentery/Secondary (0-12) | College (1-4or 5- | | | | | | -16 - | | |
| | Hygie ther ther | | 8 17. Father's Neme (First, Middla, Last) | | <u> </u> | BX Opera | | 8. Mother's Ner | ne (First, Middle, | Life I | | nce |
| Maryland | should be nd Mentel marked o | To Be | George Joseph | Mueller | | | | Helen | Rose | | | erlien |
| ary | shou mar umar | - | 19a. Informant's Name/Reletionship (T) | | 19 | 9b. Mailing Addre | ess (Street end | | | | | |
| | end 2 seith a n 27 is | | Carolyn Appel-Daug | ghter | 1 | .304 Crai | nes Bil | L1 Ct., | Unit 30 | 3, Belc | amp, I | MD 21017 |
| ore, | of He | | 20e. Mathod of Disposition | | 20b. Piece camer | of Disposition (A | ieme of | | Data | 20c. Location - | City or Tow | m, Stete |
| Ĕ | Pages nent of I ant: If Ite ury or o | | Donation 5 ☐ Other (Specify) | | | Holy Red | | Cem. | 8-25-97 | Balti | more. | Maryland |
| Baltimore, | eparti eparti nporti ny Inj | | 21. Signature of Funeral Service Licans | 70 | | 22. Nama | and Address | of Facility | III Fun | | | |
| _ | 40 5 4 M | | - Willed IV | Lloma | D | 1317 | Cokesh | oury Rd | . Abino | don. MD | | |
| | | | 23e. Part Enter the demand or compleshock, or haert feilure. List only or | ications thet caused the ceuse on each line | the deeth. Do | o not anter the m | ode of dylng, | such es cardied | or respiratory e | rrest, | | Approximata Intervel Between |
| | Physician (Madical | | | | | | | | | | | Onset and Deeth |
| | /Medical Examiner | | Immediate Ceuse (Finei disease or condition resulting in deeth) | Chol | lecyst | titis | | | | | | few days |
| | 500 | - | , | | oue to for es | e consequence o | f): | | | | | 0 |
| | d d ansit | Examiner | | Ď | Number (or on a | | 4). | | | | | |
| ó | exec an an | Еха | Sequentially list conditions, if eny, leeding to immediate cause. Enter Undarlying | | oue to (or es e | e consequenca o | т): | | | | | |
| 68760, | rificate be executed ng physician and es the buriel-transit | edical | Ceuse (Diseese or Injury that initieted evants resulting in daath) Lest | c | ue to (or as e | consequanca of | l); | | | | | |
| | = 00 | Med | | 4 | | | | | | | 1 | |
| Box | th ce thendi | lan | | J | | | | | | | | |
| o O | the a | Physician/M | Pert II. Other eignificent conditions cor | ntributing to death but | not resulting | In the underlying | g ceusa given | in Pert I. | 23b. Dfd | lobacco uee cor | tribute to t | the ceues of death? |
| P.0. | The law requires that the death cer ate hes been signed by the attendir page 2 should be deteched for use | | Parkinsons | direcin | | | | | 10 | Yes 2 No | 3 Probe | ably 4 Unknown |
| Records, | signed d be del | d by | | | | | | | 24a Was | en eutopsy | 24h War | e autopsy findings |
| Ö | v require been si should I | Completed | | | | | | | | rmed? | evail | leble prior to |
| Re | he law | d L | | | | | | | | - | | eeth? |
| | | | OF Mos sons referred to medical | | | | _ | | 10, | | 10 | Yes 2 No |
| > | slcia certi | o Be | 25. Wes case referred to medical exeminer? 1 Yes 2 No | fospitel: | • 0 CD(C | Outpetient 3 1 | | | ome 5□ Resid | | (0 //) | |
| 0 | 는 부들 | n: To | 27. Manner of Death | 28e. Date of Injury | 28b. | . Time of | 28c. fnjury et | | | now Injury occurr | | |
| 0 | Attending Ph or death. ector: After th by the funeral | atio | 1 Naturel 5 ☐ Pending investigation | (Month, Dey | Year) | Injury M | Work? 1 ☐ Yas | s 2 No | | | | |
| Division of Vital | or Attending I effer death. Director: Affer I in by the funer | Certification: | 3 ☐ Sulcida 6 ☐ Could not be determined | 28e. Plece of Injur building, etc. | y - At homa, (| farm, street, fecto | ory, office | | 28f. Location (S City or Tox | Straat and Numb | er or Rural I | Route Number, |
| ٥ | ital or is eft is Di in Di | Ce | | | | | | | | | | |
| | To the Hospital or Att within 24 hours efter d To the Funeral Direct completely filled in by | edical | 29a. Certifier (Check only one) Certifying Physical Example (Check only one) | ofclan: To the best of ner: On the basis of e | e noitenimexe | ga, daath occurre and/or investigetic | d at the tima, on, in my opini | deta and place ion, deeth occu | , and due to the rred at the time, | cause(s) and ma dete end placa, a | nner as stell and due to t | ted. he cause(s) |
| | of the | Mec | 29b. Signeture end title of certifier | end manner stet | eu. | | 9c. License n | | | 29d. Dete signed | | |
| | ⊢s⊢ő | | 1 11-1 | 0 11 | 8. | | TIC | 00 41 | 2 | 08. | | |
| | _1_ | | 30. Neme and address of person who co | mpleted cause of de | ath (Item 23s) | (Type Print) | V | (0 | | - 0 , | ت در | - 7 |
| | Mr. | | 1308 Burners | Center 1. |) | Eolojeur | ovel | MD | 2104 | 0 | | |
| | Sta | te | 31. Dete filed (Month, Dey, Year) | 32 Peroistrar | 's Signeture | 0 | 1 | | | | | |
| | Registr | ar | AUG 2 5 199 | A STATE OF S | www. | ardall | | | | | | |



State of Maryland / Department of Health and Mental Hygiene 97 27 | 42

| | | | | | | C | ertifica | ate of | Death | | F | leg. No. | | | | |
|------------|--|------------------|--|---|---------------------------------|--|---------------------------|---------------------------------|--------------------------------|--------------------------|--|---------------------|----------------------|-----------------------------|----------------------|---------------------------------------|
| | Dhamba | | Decedent's Name (First, Middle, L. | ast) | | | | | | | 2. Dete of Dea Month | th Day | | Year | 3. Tirr | ne of Death |
| | Physic /Medi | | Marion N. Draco | poulos | | | | | | | August | | | | 1:4 | 47AM |
| ì | Exami | | 4e. Fecility Name (If not institution, gi | ve street end nun | nber) | | | | 4b. City, To | wn, or Lo | cation of Death | 4c. | County | of Death | | |
| | | | 10320 Democracy | | | | | | Potom | | ~ ~ | | | gomer | У | |
| | Funeral Director | | 500-32-2407 | Sex 1□M 2ĂF | 7. Age (In yr. | s. last birthda Yrs. | y) If Und Month | der 1 Yea is Deys | | 24 Hrs. Min. | 8. Date of Birth (Month, Dey Feb. 21 | Year) | 933 | Coun | lace (State) Sour | ete or Foreign |
| | and w | | Usual Residence of Decedent 10a. State 10b. County | | 10c. C | City, Town or | Location | | | | | | | 11 | Od Insid | de City Limits |
| | he Maryl 8a-f sho | ector | Maryland Montgo | mery | | | Potom | | | | | | | | 1 🗆 | Yes 2∭ No |
| | 23e or 2 | Funeral Director | 109. Street and Number 10320 Democracy | Lane | | | | | 854 | | | | | State | | |
| 020 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once. | b | 11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced | 12. Was Dece Armed For 1 Yes If Yes, Give Year or Da | ces? 2 [2]No | U,S. 13 | | cedent of pacify Cu 2 XNo | | gin? (Spe , Puerto f | cify Yes or No- Rican, etc.) | | | e - America ck, White, c | | |
| 2-0 | 72 ho | ed a | 15. Decedent's E | ducation | | 16a. Dec | edent's Us | sual Occu | pation | t of summerin | | 16b. KI | ind of Bu | usiness/Ind | Justry | |
| 21215-0020 | I and 2 should be filed within 72 hours after Health and Mental Hygiene. Sem 27 is marked other than "natural", or in their traumatic event, the Medical Eventy. | Completed | (Specify only highest gr Elementery/Secondary (0-12) | College (1- | 4or 5+) | | omema | | pation during mosi ed) | r or workir | ng | | Own | Home | e | |
| ğ | Hygothe other | BeC | 17. Father's Name (First, Middle, Las | t) | | ļ | | | 18. Mothe | r's Name | (First, Middle, | <i>Maide</i> n | Sumem | 10) | | |
| Maryland | ked ked ic ev | ToB | Eric Nagel | | | | | | Не | len 1 | Mayer | | | | | |
| 37 | and M | - | 19a. Informant's Name/Relationship | (Type, Print) | | 19b. Ma | ilina Addre | ss (Stree | | | I Route Numbe | r. City o | or Town. | Stete. Zio | Code) | |
| Š | Ith a | | John W. Dracopou | 2.111 | and | | | | | | Potomac | | | | | 5/4 |
| Baltimore, | Pages 1 ar nent of Hea nnt: If item ury or othe | | 20a. Method of Disposition 1 | ☐Removal from S | 20b. | Place of Dis cemetery, cr | position (A remetory o | leme of r other pl | ece) Aug | . 28 | , 1997 | 20c. Lo | ocation - | City or To | wn, Stat | te |
| | it. P. | | 4 Donation 5 Other (Speci | | Pa | rklawn Memorial Park Rockville, 1 22. Name and Address of Facility Robert A. Pumphrey Fun | | | | | | | | | | |
| Pa Ba | Departiment of the control of the co | | 21. Signature of Funeral Servica Lice | P. Ki | II a MC | 00348 | Bethe | and Add sda- | Chevy | Chase | ert A. e. Inc. 20814- | Pump | phre 557 | y Fur Wisco | nera onsi | 1 Home n Ave. |
| | Physician /Medical Examiner | liner | Immediate Cause (Final disease or condition resulting in deeth) | a. Meta | | Adeno | | | a of L | eft] | Lung | | | | | nths |
| 68760, | eath certificate be executed attending physician and for use as the burial-transit | Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Infliated events resulting in death) Last | Due to (or es a consequence of): C Due to (or as a consequence of): | | | | | | | | | | | | |
| Box | th certifications are as | an/Me | C | d | | | | | | | | | | | | |
| | the at | Physician | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Dld to | bacco | use cor | ntribute to | the car | use of death |
| s, P.O | that the ed by detac | by Phy | | | | | | | | | 1 <u>X</u> | es 2 | □ No | 3 Prob | ably | 4 Unknow |
| Hecord | aw requires been s | Completed | | | | | | | | | 24a. Was a partor | n autor med? | osy | ave | ailable pi | psy findings rior to n of cause |
| r | The ate h | Con | | | | | | | | | 1 □ Y | es 2 | XNo | 1 | Yes | 2 🗆 🗓 No |
| Vitai | ician: The certificate rector, pag | Be | 25. Was case referred to medical examiner? | | | | | | 26. Place | of Deeth | (Check only or | 10) | | | | |
| 0 0 | D 00 Z | 2 | 1 ☐ Yes 2 No | Hospital: 1 ☐ in | patient 2[| ☐ ER/Outpati | ent 3 🗆 I | DOA | ther: 4 Nu | rsing Hon | ne 54 Resid | ence (| 6 Oth | er (Specify | 1) | |
| | After fune | | 27. Manner of Deeth 1 | | finjury n, Dey Year) | 28b. Time Injury | of M | 28c. Inji W | ıryat ork?]Yes 2 □ I | | 28d. Describe h | ow injur | y occurr | red | | |
| DIVISION | s after death in Director:. | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined | 289. Placa | of Injury - At g, etc. (Spec | home, farm, s | street, fact | ory, office | | 2 | 28f. Location (S City or Town | | | er or Rure | / Route | Number, |
| | To the Hospital or within 24 hours after To the Funeral Dirt completely filled In | edical (| 29a. Certifier (Check only one) WXCertifying Pr | nysictan: To the bas miner: On the bas and manne | sis of examin | nowledge, dec nation end/or | eth occurre | ed at the ton, in my | ime, dete and opinion, deat | d plece, e th occurre | and due to the co | euse(s) late end | and me i piece, i | enner as st and due to | ated. the cau | ise(s) |
| | withi To th | × | 29b Signature and title of certifier | | | _ | 2 | 9c. Licer | se number | | 2 | 9d. Dat | le signe | d (Month, I | Day, Ye | ar) |
| 2 | 20 | | Jamel 30 North | Brown | regli | 11) | - D-!!` | D07 | 285 | | A | ugus | st 2. | 5, 19 | 97 | |
| | | | James A. Brown. | | | | | n D | | 200 | D 1 | 1 1 | 3.00 | 000 | 15.0 | |
| | Sta | ite | James A. Brown, A | 1997 32. Re | gializata Sign | Sturg Ann | Rendel | L DT. | ive, # | JUU, | KOCKV1 | тте, | , MD | 208 | 50 | |

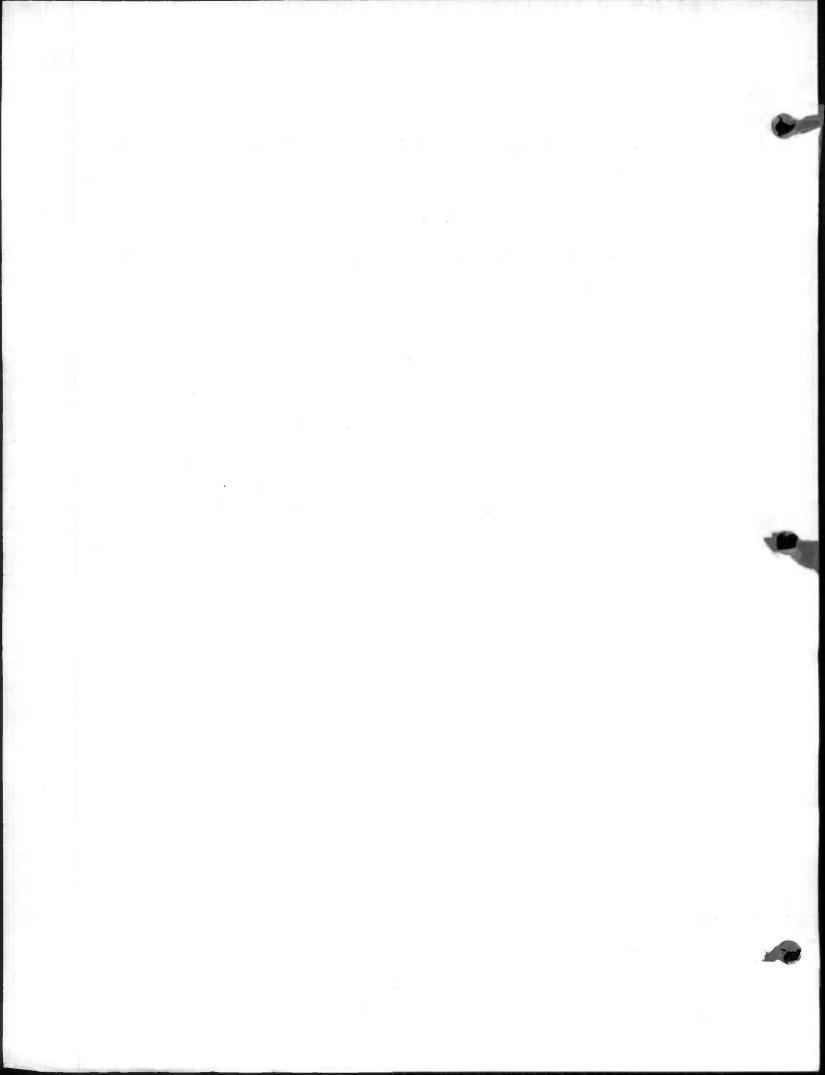


State of Maryland / Department of Health and Mental Hygiene 97 2711, 3

| | | | Certificate | of Death | F | Reg. No. | 1 6- | 1140 |
|--------------------------|---|--|--|--|----------------------------------|--------------------|------------------------------|--------------------------------------|
| Dhuaisian | 1. Decedent's Name (First, Middle, I | Last) | | | 2. Dete of Dea | | Yeer | 3. Time of Death |
| Physician /Medical | | Marjorie B. | Doherty | | August | 25, 199 | 7 | 9:20 PM |
| Examiner | An Physille, Manney Hd and Innale, direct | rive straet end number) | | 4b. City, Town, or L | | 4c. County | of Deeth | |
| A.U. | 3310 North Leisu | re World Blvd. | #1027 | Silver Sp | | | tgomer | .7. |
| Funeral Director | 5. Social Security Number 6 012-05-9368 | 1 □ M 2 1 3 F | (last birthdey) If Under 1 Months I | Yeer If Under 24 Hrs. Deys Hours Min. | (Month, De) | Year) | 9. Birthple Country | ce (Stete or Foraign |
| niector : | Usuai Residence of Decedent | 81 | | | reb. 12 | , 1916 | Massa | chusetts |
| show | 10e. Stete 10b. County | 10c. Ci | ity, Town or Locetion | | | | 100 | d. Inside City Limits |
| 28a-f sh motified | Maryland Montgom | nerv Si | lver Spring | | | | | 1 Yes 2 No |
| Director | 10e. Street end Number | | 10f. Zip Co | ode | | 10g. Citizen of V | Vhat Country | y? |
| Tal Cal | 3310 North Leisun | re World Blvd., | #1027 20 | 906 | | United | Stat | es |
| Funeral | 11. Maritai Status | 12. Wes Decedent Ever in U Armed Forces? | J,S. 13. Was Deceder If Yas, specify | nt of Hispenic Origin? (Sp Cuban, Mexican, Puerto | ecify Yas or No- Rican, atc.) | | a - Amarican k, White, et | |
| ompleted by Fi | | If Yas, Give | 1 ☐ Yes 2 ☐ | No Specify: | | Specify | ,. | |
| | | Year or Detes: | 16a Dandarila Haval 6 | Parametica. | 1 | ACE Vindad D | | hite |
| Completed | 15. Decadent's (Specify only highest g | rede completed) | 16a. Decedent's Usual C (Give kind of work) life. DO NOT use | done during most of work | ring | 16b. Kind of Bu | isiness/inqu | istry |
| To Be Comp | Eiementery/Secondary (0-12) | College (1-4or 5+) | Executive | · | | Enginee | rina | |
| Be | 17. Fether's Name (First, Middle, La. | st) | LACCUCIVE | 18. Mother's Nam | e (First, Middle, | | | |
| ToB | George Burdet | t. | | Ethel | MacDona | ald | | |
| | 19a. Informent's Neme/Reletionship | | 19b. Meiling Address (S | Street and Number or Run | | | Stete, Zip C | Code) |
| | Andrew Doherty | | 4412 Skymis | t Terrace, | Olney, | MD 208 | 32 | |
| | 20e. Method of Disposition 1 Buriel 2 Cremetion 3 | 20b. I | Plece of Disposition (Neme cemetery, cremetory or other | of er plece) | Deta | 20c. Location - | City or Tow | n, State |
| once. To Be Com | 4 Donetion 5 Other (Space | | esapeake Cre | matory 8 | -26-97 | Beltsvi | lle, l | Maryland |
| once. | 21. Signatura of Funeral Service Llc | / // | Dann Eur | Address of Fecility | nos D | ٨ | f | |
| a | 23e. Pert1. Enter the disease, or co shock, or heart feilure. List on | 1. Kapp | 933 Gist | neral Service | ilver Sn | A. rina M | n 200 | 10 |
| | 23e. Pert1. Enter the disease, or co shock, or heart feilure. List on | mplications that caused the dae | th. Do not enter the mode of | of dying, such es cerdiec | or respiratory ar | rast, | | Approximete nterval Between |
| n | | • | | | | | | Onsat and Deeth |
| al er | Immediate Ceuse (Finel disease or condition resulting in deeth) | Lung Canc | er | | | | 6 | months |
| ш. | resulting in deeth) | Due to (| or as a consequence of): | | | | | |
| edicai Examiner | _ | Respirato | | | | | | |
| Exar | Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury | Due to (| or es e consequence of): | | | | | |
| | Ceuse (Disease or injury that initieted events | C. Due to (| | | | | | |
| ledicai | resulting in deeth) Lest | Due to (c | or es e consequence of): | | | | | |
| M/N | | d | | | | | | |
| Physician/ | Pert II. Other algnificant conditions | contributing to death but not re- | sulting in the underlying cau: | se given in Pert i. | 23b. Did t | obacco use co | ntribute to t | the cause of death? |
| Phy | | | | - | 1 10 | as 2 No | 3 Probe | bly 4 Unknown |
| leted by Physic | | | | | | | | |
| ted | | | | | 24a. Wes o | en eutopsy med? | aveil | e autopsy findings labla prior to |
| Completed | | | | | | | | pletion of causa eath? |
| o Be Compi | | | | | 1 🗆 Y | es 2 No | 1 🗆 | Yas 200 No |
| Be | 25. Was case referred to medical examiner? | | | 26. Plece of Deet | h (Check only o | ne) | | |
| 2 | 1 ☐ Yes 2X No | | ER/Outpetient 3 DOA | + | ome 5 X Resid | | | |
| lo | 27. Manner of Death 1 □Naturel 5 □ Pending | 28e. Dete of Injury (Month, Dey Year) | | . Injury et Work? | 28d. Describe h | ow injury occurr | ed | |
| Medical Certification: 7 | 2 Accident investigati 3 Sulcide 6 Could not | be as Plant think the | M M | 1 Yes 2 No | 28f. Location (S | Street and Numb | er or Pumili | Poute Alimber |
| erti | 4 Homicide determine | building, etc. (Special | ome, ferm, streel, fectory, o fy) | лпса | City or Tow | n, State) | er or nurer i | riodie rydiliber, |
| <u>a</u> | 29a. Certifier 11X Certifying F | Physician: To the best of my kno | wiedge deeth occurred at t | the time date and place | end due to the o | eause(s) and me | nner es sta | ted |
| edicai | (Check only 2 Medical Exa | aminer: On the besis of examine end menner stated. | etion end/or investigetion, in | my opinion, death occur | red et the time, o | date end place, | and due to t | he cause(s) |
| ĭ. | 29b. Signetura and title of certifiar | 0 | 29c. L | icense numbar | 1 | 29d. Date signa | d (Month, Di | ay, Year) |
| | 1 Isolelle | Ulla- | _ | D45014 | | August | 26. 1 | 997 |
| | 30. Neme and address of person who | o completed cause of death (item | | | | | , | |
| | Isabella C. Mart | | 418 Olandwood | d Ct. Ste | 111 01 | nev Ma | rvlan | d 20832 |
| State | 31. Dete tiled (Month Port 62) 7 | 1007 32. Registrar's Sign | ature - | | | nog _ 110 | T. J. Latt | uL003L |
| egistrar | HUU 27 | 1997, Julie Da | udson-hondall | | | | | |

Division of Vital Records, P.O. Box 68760,

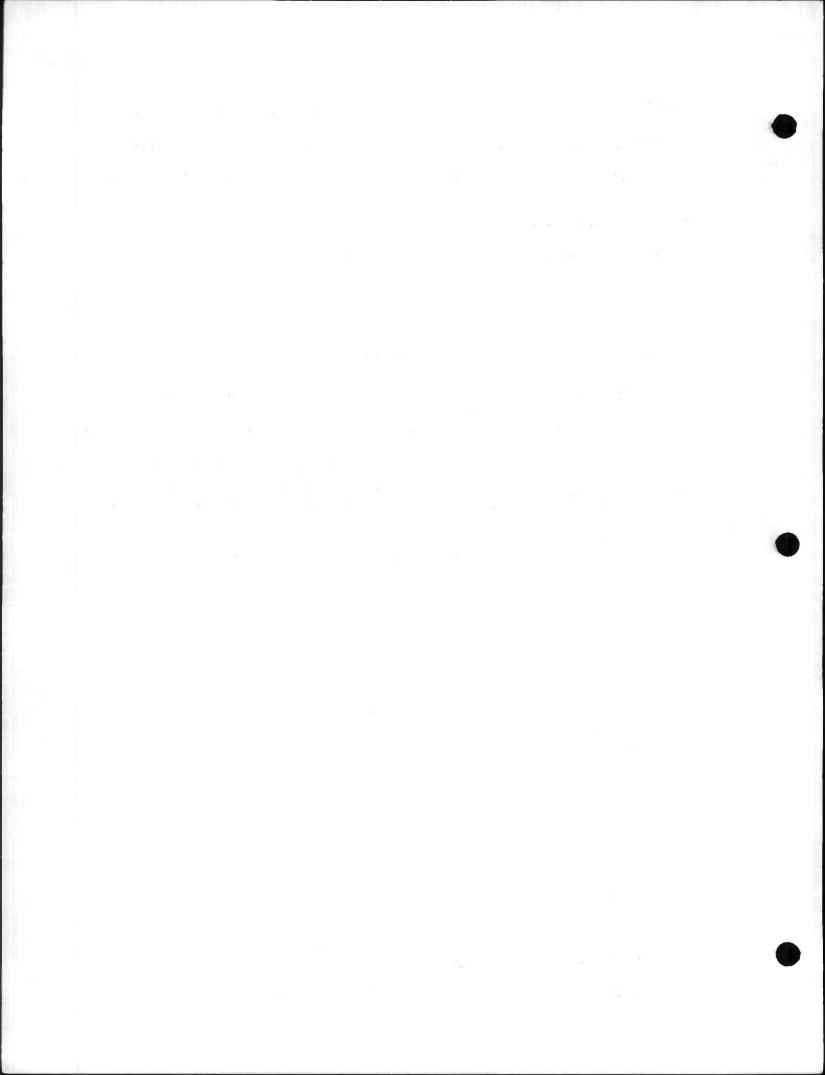
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| (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s and manner stated. | letely filled | edical Ce | (Check only 2 Medical Examiner: On the basis of exemination end/or investigation, in my opin | a, date end plece, and nion, death occurred | d due to the ceuse et tha time, data | e(s) and manr and place, an | ner as stete | d. e cause(s) |
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| 30. Nema end addrass operson who completed cause of death (Item 23e) (Type, Print) | | - | 30. Nema end addrass a person who completed cause of death (Itam 23a) (Type Print) | // | 1 | 3 -> | 11 | |
| D. D. Wileskey D. C. I. C. | | | - De Vilaber | D - (| ·1. C | | 11 - 4 | 2090 |
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9.7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Willie B. Davis August 22, 1997 7:20 PM 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Ilver Spring Genesis Eldercare - Layhill Center Silver Montgomery 5. Social Security Number If Under 1 Yeer 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) Days Hours 1⊠M 2□F Months Min. 577-05-1004 101 1895 Dec. 13, Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14400 Homecrest Road 20906 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritel Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☐ No Specify: 3 ₩ Widowed 4 Divorced Year or Dates: WW I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Surneme) William Henry Davis Mabel Potts 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 225 Vista Lane Robert C. Burns Lusby, Maryland 20657 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Suriai 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 8/25/97 Brentwood, Maryland Fort Lincoln Cemetery 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Francis J. Collins Funeral Home, Inc. ter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, heart tailure. List only one cause on each line. 500 University Blvd., W., Silver Spring, MD 20901 Approximate Interval Between Onset and Deeth PNEOHONIA Immediete Cause (Final diseese or condition resulting in deeth) Due to (or as a consequence of):
NEO HO THORAX Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of); Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Munknown 24a. Was an autopsy performed?

Physician /Medicai **Examiner**

that the death certificate be executed

P.O. Box 68760.

Records,

of Vital

Division

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Director

Funeral

þ

Completed

Be

2

with the Marylend

death

filed within 72 hours after

I Hygiene.

Pages 1 end 2 should be fill ment of Health and Mentel Hant: If them 27 is marked out

permit. Pages 1 end 2:
Depertment of Health as Important: If Item 27 is any injury or other trau

22.5-0020 ■ Baltimore, Maryland 21215-0020

Physician/Medical Examiner þ Completed Be

physician and s the burial-trans 88 2 signed be del peeu page 2 certificate Hospital or Attanding Physician: 24 hours efter death. Funeral Director: After this certifica etely filled in by the funeral director, I Certification: To To the Hospital or within 24 hours efter To the Funeral Dir completely filled in Medical

24b. Were autopsy findings available prior to completion of cause of death? 2 2000 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 8 Could not be 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

DO6406

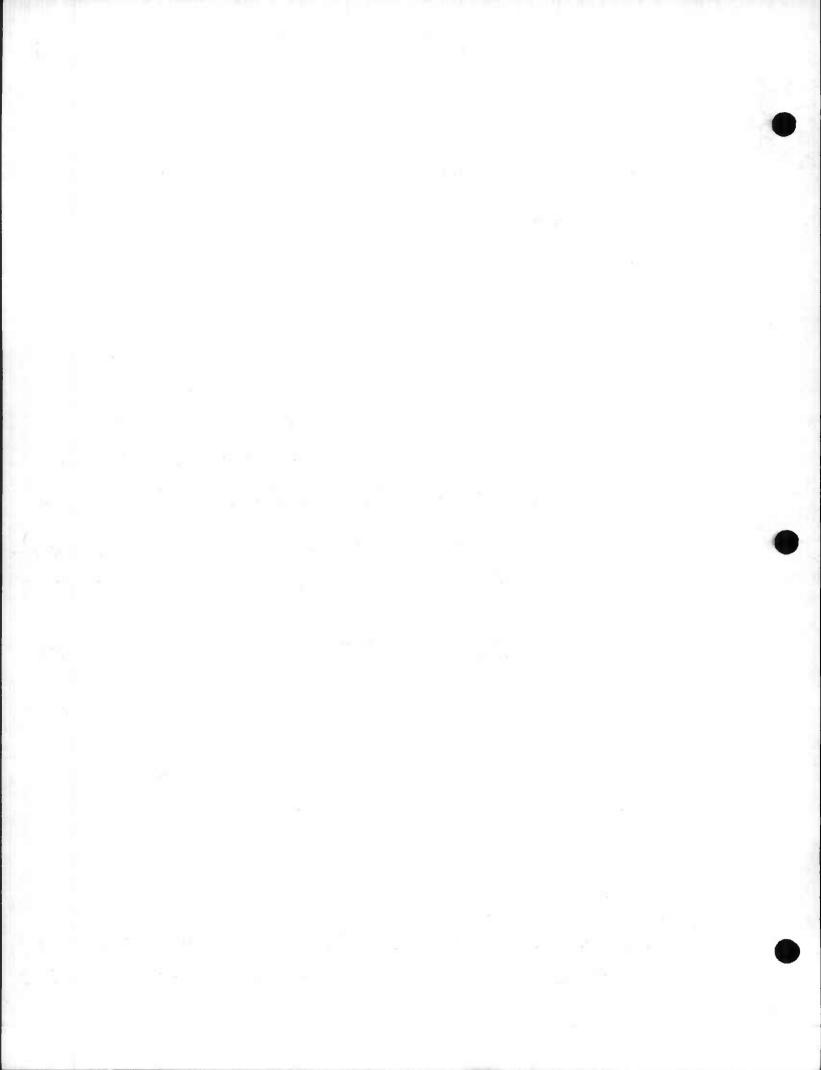
+

Name and address of person completed cause of death (Item 23a) (Type, Print) DONALD EWIS

Signature and title of continue

4000 RT108 OLHEY, 4020832 32. Registratis Signature
Sucha Sawdson-Rondolle

State Registrar

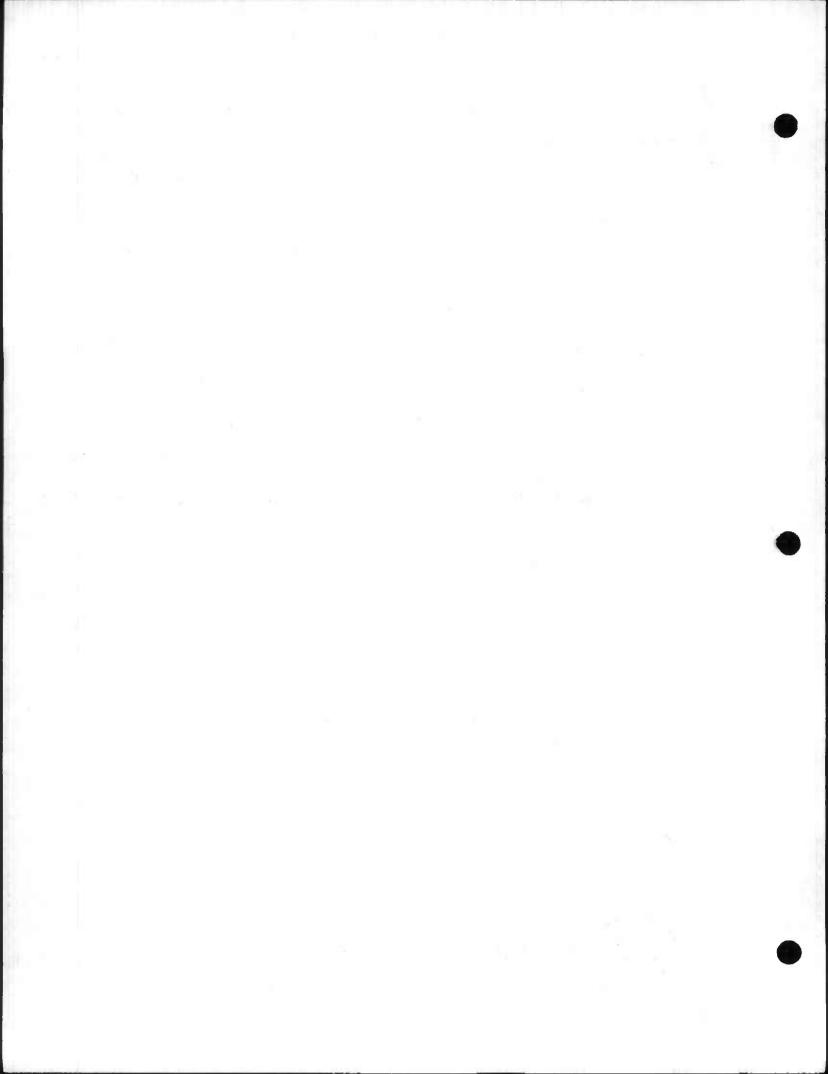


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death Month **Physician** Paul James Edmonds 08 12 97 2:30pm /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Sacurity Number If Undar 1 Year | If Under 24 Hrs. 6. Sax 7. Aga (In yrs. last birthday) Birthplace (State or Foraign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months 1 NM 2 □ F Days Yrs. 561-34-9564 Director 73 01-11-24 Indiana Usual Residence of Decadent the Maryland 10a. Stata 10b. County 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be multiped at 10c. City. Town or Location 10d. insida City Limits Director Maryland Montgomery 1 Yas 2 □ No Bethesda 10e. Street and Numbar 10f. Zip Coda 10g. Citizen of What Country? 7513 Springlake Drive Apt. 2 20817 USA Funeral 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. Pages 1 and 2 should be filed within 72 hours effer on ent of Health and Mental Hygiena.
Int: If item 27 is marked other than "natural", or item
Inty or other traumatic event, Ite Medical Eventine.
Inty or other traumatic event, Ite Medical Eventine. 1 ☐ Navar Married 2 ☑ Married No. Yes 2 No. No. No. No. Baltimore, Maryland 21215-0020 1 ☐ Yas 2 XNo Specify: à Specify: 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: 41-45 White Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15 Decedent's Education 16b. Kind of Business/Industry (Spacify only highast grada complated) Eiamentery/Secondary (0-12) Collega (1-4or 5+) Television Engineer 17. Father's Nama (First, Middia, Last) 18. Mother's Nema (First, Middle, Maiden Surnama) William E. Edmonds Louise Pelt 19a. tnformant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Frances M. Edmonds/Spouse 7513 Springlake Drive Bethesda, MD 20817 20b. Placa of Disposition (Name of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burlai 2 Cramation 3 Ramoval from Stata permit. Page Department of Important: If any Injury or 08-14-97 Round Hill, VA 4 Donation 5 Dother (Specify) Ebenezer Cemetery 21. Signature of Funaral Sarvice Liq 22. Nama and Addrass of Facility Hall Funeral Home, Inc. Box 896 Purcellville, VA 20134-0896 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervai Batwaan Onsat and Death **Physician** /Medical tmmediata Cause (Final Pancreatitis 5 days disease or condition resulting in death) Examiner Dua to (or as e consequence of): Examiner Diffuse Athesesclerotic Vascular Disease years 5+ physician and the burial-transit Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Diseasa or Injury that Initieted events rasulting in daath) Last Dua to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Hyperlipidemia years 5+ Physician/Medical Dua to (or as a consequence of): Part il. Other etgnificant condittone contributing to death but not resulting in the undarlying cause given in Part I. the 23b. Did tobecco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown signed t Lung Cancer by 24b. Ware autopsy findings available prior to complation of cause of death? 24e. Was an autopsy Completed peed Upper Gastrointestinal Bleed performad' has 1 Yas 2 No certificate 1 ☐ Yes 2 ☐ No Be 25. Wes casa referred to medical axaminar? 26. Piaca of Death (Check only ona) Hospital: 2 Othar: 4 Nursing Home 5 Residanca 6 Other (Specify) 1 Yas 2 No 1 Nopatiant 2 ER/Outpatiant 3 DOA \$4 28a. Data of injury (Month, Day Year) uneun 27. Mannar of Death 28b. Tima of 28c. injury at Work? Certification: 28d. Dascriba how injury occurred After Attending 5 Panding invastigation 1 X Natural death. 1 ☐ Yas 2 ☐ No after death Director: / 2 Accident 6 Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 28a. Place of injury - At homa, farm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours at To the Funeral D Medical 29a. Cartifier 1 CCertifying Physictan: To the best of my knowledge, death occurred at tha time, date end piece, and dua to tha cause(s) end manner es statad.
2 Medical Examiner: On the bests of examination end/or invastigetion, in my opinion, death occurred at the time, date and piece, end dua to the cause(s) end mannar steted. (Check only one) 29b. Sanature 29c. Licansa number 29d. Data signed (Month, Day, Year) doress of person who completed ceusa of daath (item 23e) (Type, Print) Prive, Bethesda, Med 20017 5600 8hidds & 31. Ditter filed (Month, Day, Yaar) 32. Registrer's Signatura State

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Registrar

AUG 21 1997



State of Maryland / Department of Health and Mental Hygiene 97 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Day **Physician** JOSEPH FAGGIO JOSEPH 18, 4:10 A.M. AUGUST 1997 /Medicai 4a. Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** CHESAPEAKE HOSPICE HOUSE LINTHICUM ANNE ARUNDEL If Undar 1 Yaar If Undar 24 Hrs.
Months Deys Hours Min. 7. Aga (In yrs. last birthdey) 9. Birthpiece (Stata or Foreign 8. Deta of Birth (Month, Dey, Year) **Funeral** Months Deys MARYLAND 216-05-9252 76 Yrs Director DEC. 3, 1920 Usual Residence of Decedent with the Maryland 10e. State 10b. County 10c. City, Town or Location ir than "natural", or Items 23s or 28s-f show the Medical Examiner near be notified at 10d, Inside City Limits 1 Yas 2 No MARYLAND ANNE ARUNDEL GLEN BURNIE Directo 10f. Zip Code 10e. Street end Number 10g. Citizen of What Country? 619 ELIZABETH ROAD 21061 U.S.A. death Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? 11. Meritai Stetus Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian. Black, White, atc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Healin and Mental Hygiene. Important: If them 27 is marked other than "natural", or the any injury or other traumatic event, If a way, at 1 X Yes 2 □ No If Yes, Give Year or Datas: 1 Navar Married 2 Married 1942-Baltimore, Maryland 21215-0020 1 ☐ Yas 2 🔀 No Specify: þ WHITE 3 Widowed 4 Divorced 1945 Completed 16a. Decedent's Usuei Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) SALESMAN N/A FRUIT/PRODUCE 17. Fether's Nema (First, Middle, Last) 18. Mother's Nama (First, Middle, Meiden Sumeme) Be ROSARIO FAGGIO CONCETTA MARSIGILA 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) LILLIAN FAGGIO 619 ELIZABETH ROAD, GLEN BURNIE, MD. 21061 (WIFE) 20b. Plece of Disposition (Nema of cemetery, crametory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Remove from Stete MEADOWRIDGE MEMORIAL PARK 8/21/97 ELKRIDGE, MARYLAND 4 Doddtion 5 Duner (Specify) 22. Nema end Address of Fecility SINGLETON FUNERAL HOME, 21. Signature of Fuperal Service The any ir 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 a, or somplications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, List only one cause on each line. Approximete Interval Between Onset and Death Lenter the disease. Le or heert feilure. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 1 year Examiner Due to (or es a consequence of Physician/Medical Examiner The law requires that the deeth certificate be executed attending physicien and for use as the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Undarlying Cause (Disaesa or Injury Due to (or es e consequence of): Box 68760 thet Initiated evants Dua to (or as a consequence of) resulting In deeth) Lest Division of Vital Records, P.O. Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contributs to the cause of death? the signed by 25 No 1 Yes 3 Probably 4 Unknown Ď 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed Deen has 20 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: director Be 25. Was case referred to medical exeminer? 26. Plece of Death (Check only one) Hospitel: Othar: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yas 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Menner of Deeth 28d. Dascribe how injury occurred 28e. Dete of injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? After 5 Pending Invastigation 1 Neturel n 24 hours efter death.

Ne Funeral Director: Af pletely filled in by the ft death. 1 Yes 2 No ₽ ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 3 Suicide 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 - Homicide the Hospital 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner as steled.
2 Madical Examinar: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) and manner stated. edicai 29e. Certifier (Check only one) within 2 29b. Signeture and title of certifier 29c. License number 0 MID 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) 300LS. Hanove ospital Cen Noor GADDA

State Registrar

AUG 1 9 1997

31. Data filed (Month, Dey, Year)

32. Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene 97 271

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** AUG. 26, MAUDE MARINE FARINHOLT 1997 10 P.M. /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6211 BETHLEHEM ROAD PRESTON CAROLINE H Under 24 Hrs.
Hours Min.
SEPT. 10, 1911 If Under 1 Year Months Days 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 9. Birthplece (State or Foreign **Funeral** 1□M 25 F Yrs MARYLAND **Director** 219-05-8841 85 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or items 23a or 28a-f show other traumetic svent, the Medical Examinar must be notified at 10d. Inside City Limits 1 Yes 2 No Director MARYLAND CAROLINE PRESTON 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6211 BETHLEHEM ROAD 21655 U.S.A. death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Yeer or Detes: 14. Race - American Indian, Bleck, White, etc. 11. Meritei Stetus Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 WHITE 1 Yes 2 XNo 2 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) HOMEMAKER OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) JOHN RICHARD MARINE SALLIE FLUHARTY ဥ 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) RONALD TODD / SON 25550 BEAUCHAMP RD., DENTON, MD 21629 20e. Method of Disposition

1 Deurial 2 Cremetion 3 Removel from Stete 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, State 8-30-97 FEDERALSBURG, MD HILLCREST CEMETERY 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility FELLOWS, HELFENBEIN, NEWNAM 21. Signeture of Funerel Service Licensee 200 S. HARRISON ST., EASTON, MD. 21601 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical ACUTE CEREBRAL VASCULAR ACCIDENT ACUTE Examiner Due to (or es a consequence of): Examiner CHRONIC PREVIOUS STROKES sician end burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): physician es the burial CHRONIC Box 68760 HEART DISEASE Physician/Medical Due to (or es e consequence of): 98 USB lor detached Records. P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yss 2 No 3 Probably ★ Unknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Wes an autopsy peed performed? has page 2 certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific director. 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 M Residence 8 Other (Specify) 1X Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) funeral 27. Menner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 1 X Neturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident the 8 Couid not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) yd ni bellii 4 Homleide 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end manner stated. 29b. Signyfuryni 29c. License number 29d. Dete signed (Month, Dey, Year) D 14664 AUG: 27, 1997 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) CHRISTIAN E. JENSEN, M.D. P.O. BOX 690 DENTON, MD. 21629 AUG 2 9 32. Registrers Signeture State 1997 wha Davidson-Randell Registrar

DHMH 16 Rev 6/95

Committee and the Committee an a, 2 | 15,22 | 11

State of Maryland / Department of Health and Mental Hygiene

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| Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hyglene. Separtment of Health and Mental Hyglene. Any Injury or other traumatic event, the Medical Examiner must be notified at 2008. | Be Completed by Funeral Director | | ry/Secon | dary (0-12 | 2) |
| Baltimore, Maryland 212 permit. Pages 1 and 2 should be filed with Department of Health and Mentel Hyglene Important: If flam 27 is marked other than any Injury or other traumatic event, that pages. | Be C | 17. Father's | Name (F | First, Midd | lle, i |
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| ari | t I,27,28a-f per MEO G-751 9/1 | 6/97 dh | Certifica | ate of | Death | | Reg. No. | | |
|-------|---|--------------------------|---|-------------------------|---------------------------------------|------------------------------------|------------------------|------------------------------|--|
| _ | . Decedent's Name (First, Middle, Last) | | | | | 2. Date of D | eath Day | Yeer | 3. Time of Death |
| | Kenneth Dwight Friend | l,Jr. | | | | AUG. | 24, | | 0745 AM |
| 4 | e. Facility Name (If not institution, give street and nu | n <i>ber)</i> | | | 4b. City, Town, or | Location of Dee | T | ounty of Deeth | |
| | 407 REISTERSTOWN ROAD | ROOM 2 | 39 | | PIKESVI | LLE | В | ALTIMO | RE |
| 5 | . Sociel Security Number 6. Sex | 7. Age (In yrs. | | der 1 Year | | | irth | 9. Birth | place (State or Foreig |
| 2 | 20-68-7686 ^{12⊠ M 2□ F} | 39 | Yrs. Month | hs Deys | Hours Min | | | 8 Mary | |
| - | Sual Residence of Decedent | 1.0 | | | | | | | |
| Ι. | 0a. State 10b. County | 10c. Cit | y, Town or Location | | | | | | 10d. Inside City Limits |
| | Maryland Talbot | Eas | ston | | | | | | 1 Yes 205No |
| 1 | 0e. Street and Number | | 10f. | Zip Code | | | 10g. Citizer | n of What Cou | intry? |
| | 212 S. Aurora Street | | 21 | 601 | | | USA | | |
| 1 | Maritel Stetus 12. Wes Dece Armed Fo | dent Ever in U, rces? | | cedent of | Hispanic Orlgin? (Span, Mexicen, Puer | Specify Yes or Notice Ricen, etc.) | 0- 14. | Raca - Ameri Black, White | |
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| | 3 ☐ Widowed 4 ☐ Divorced Year or D | ates: | | | | | | B1 | .ack |
| | 15. Decedent's Education (Specify only highest grade completed) | | 16e. Decedent's U (Give kind of | work done | during most of wo | orking | 16b. Klnd | of Business/Ir | ndustry |
| | Elementary/Secondary (0-12) College (1 | -4or 5+) | life. DO NO | | od) | | | | |
| - | 12th | | Truck Dr | iver | T 40 34-W-4-N | (F) 1414 H | | Compa | iny |
| | 7. Father's Name (First, Middle, Last) | | | | | me (First, Middle | s, Maiden Su | meme) | |
| | Kenneth D. Friend, Sr. | | T | | Bessi | | | | |
| | 9a. Intormant's Name/Relationship (Type, Print) | | 19b. Mailing Addr | | | | | | |
| - | Kenneth D. Friend, Sr. (fa | | | | Court, Ea | | | | |
| 2 | 0a. Method ot Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removel from | | lace of Disposition (femetery, crematory of | vame of or other pie | ice) | Date | 20c. Local | llon - City or T | own, State |
| | 4 ☐ Donetion 5 ☐ Other (Specify) | | . Pleasant | Ceme | etery | 8/29/97 | Prest | on, Ma | ryland |
| 2 | 1. Signature of Funeral Service Licensee | | | | ess of Facility | . 1 77 | | | |
| | | | P.O. | Box | nith Fune 1687, Ea | eral nom | e arvlar | d 216 | 01 |
| 2 | 23a. Part 1. Enter the disease, or complications that c shock, or heart tailure. List only one cause on e | aused the deat | | | | | | i | Approximete Interval Between |
| | | worr mro. | | | | | | | Onset and Death |
| d | mmediate Cause (Final lisease or condition COC | AINE INTO | XICATION | | | | | | |
| | esulting in death) | | r as a consequence | ot): | | | | | |
| | | | | | | | | | |
| Sif | sequentially list conditions, | Due to (o | r as a consequence of | ot): | | | | | |
| | sequentially list conditions, any, leeding to immediate ause. Enter Underlying ause (Disease or Injury | | | | | | | 1 | |
| t | net Initiated events esulting in death) Last | Due to (or | r as a consequence of | ot): | | | | | |
| | | | | | | | | | |
| P | d | | | | | | | | |
| P | art II. Other algniftcant conditiona contributing to de | ath but not res | ulting In the underlyin | g ceuse gi | ven in Part I. | 23b. Dtd | tobacco us | e contribute | to the cause of death |
| | | | | | | 1 🗆 | Yes 23 | No 3 Pro | obably 4 Unknow |
| - | | | | | | | | | |
| | | | | | | | s an autopsy ormed? | 81 | Vere autopsy findings veilable prior to |
| . ~ | | | | | | | | of | ompletion of cause f death? |
| | | | | | | 150 | Yes 2□1 | No 1 | ¥Yes 2□ No |
| | 5. Was cese reterred to medical examiner? | | | | 26. Place of De | ath (Check only | one) | | |
| | Hospital: | npatient 2 | ER/Outpatient 3 | DOA Ot | her: 4 Nursing | Home 5 □ Res | idenca 👯 | Other (Spec | ity) MOTEL |
| 2 | 7. Manner of Death 1 □ Neturel 5 □ Pending (Mont | of Injury | 28b. Time of A | 28c. Inju | ry at | 28d. Describe | how Injury | ccurred | |
| | 2 Accident investigation found: | | found: 5:30 | | Yes 2/XNo | unknown | | | |
| | 3 Suicide 6 LiCould not be 28e. Place | | me, farm, street, fact | tory, office | | 28t. Location | (Street end I | Vumber or Rui | ral Route Number, terstown Rd. |
| | hotel | | | | | 3.17 | .,, 4 | OF ICEIS | cerscowii ku. |
| 2 | 9a. Certifier 1☐ Certifying Physician: To the | best of my know | | | | | | | |
| | (Check only one) Medical Examiner: On the ba | er stated. | tion end/or investigeti | ion, in my | opinion, death occ | urred at the time | , date and pl | ace, and due | to the cause(s) |
| 2: | 9b. Signature and title of certifier | | | | se number | | | igned (Month | |
| | Nonald & Wrigh | WMO | | 0. | C.M.E | | AUG. | . 24, 1 | 1997 |
| 30 | Name and address of person who completed caus | a of death (Item | 23a) (Type Print) | _ | | | | | |

111 Penn Street, Baltimore, Maryland 21201

State Registrar

DONALD 31. Date tiled (Month, Day, Year)

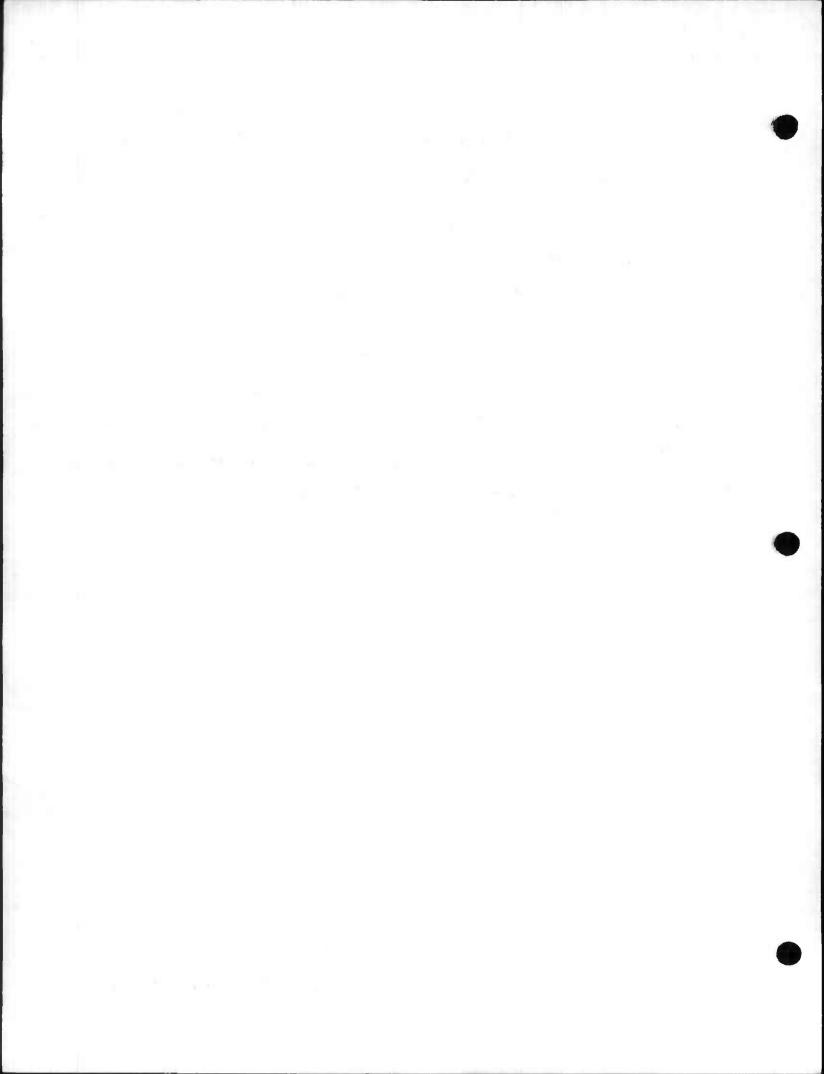
G WRIGHT MD

AUG 2 9 1997

To the Hospital or Attending Physicien: The law requires that the death certificate be executivithin 24 hours efter death.

To the Funeral Director: After this certificate hes been signed by the ettending physician end completely filled in by the funeral director, page 2 should be detached for use es the buriel-tran

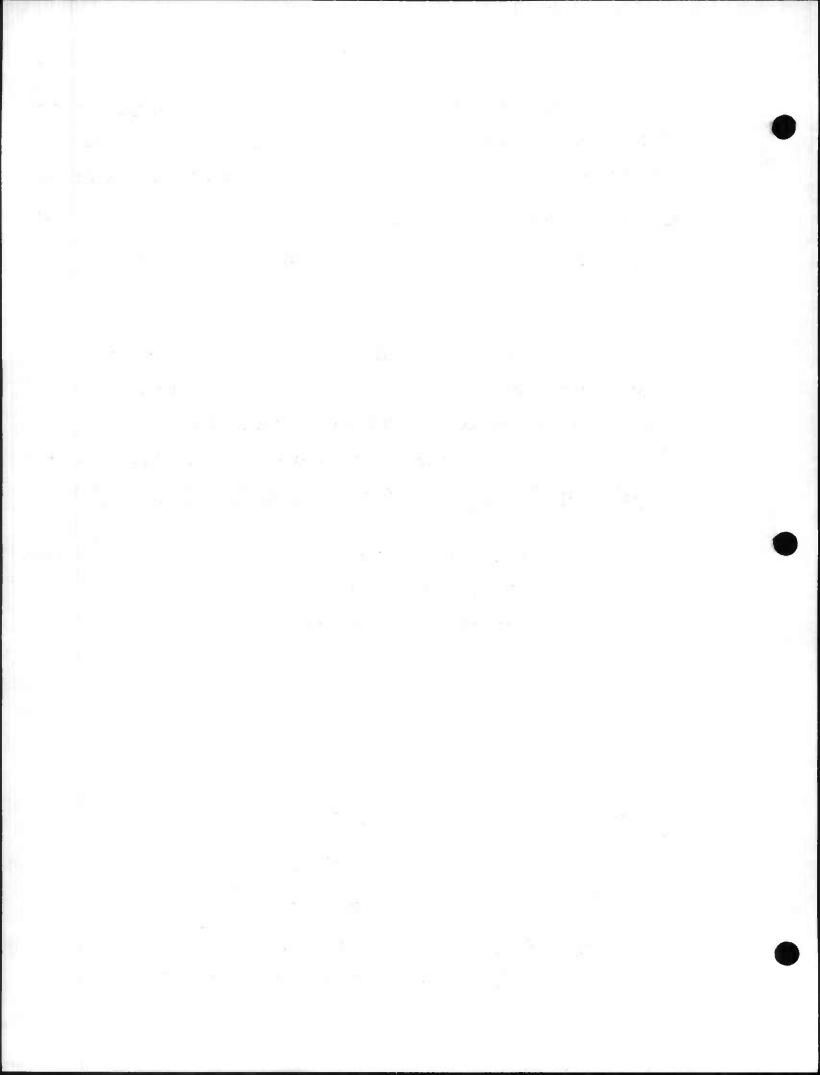
Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 27150

| | | | | | | | | Death | | Reg. No. | 1 6 | . / 0 | U |
|-------------------|--|-----------------|---|---|---------------------------------------|----------------------------|------------------------------|---|------------------------------|-----------------------------------|-------------|---------------------------------------|--------|
| | Obvoio | - | Decedent's Nama (First, Middla, Last | st) | | | | | 2. Data of De Month | ath Day | Yaar | 3. Tima of De | eath |
| | Physici /Medi | | BARBARA MAI | JRE FRANK | LIN | | | | August | 24 | | 7:45 | PM |
| | Exami | | 4e. Fecility Nama (If not institution, give | a street and number) | | | | 4b. City, Town, or | Location of Death | 4c. County | | | |
| | | | Fallston Genera | al Hospita | 1 | | | Fallst | on | F | Harfo | rd | |
| Т | Funeral | Г | 5. Social Security Number 6. S | | e (In yrs. last birth | day) If U | ndar 1 Yaar ihs Days | | 8. Data of Bir (Month, Da | th Venel | 9. Birthp | laca (Stete or F | oraign |
| | Director | | 052-12-7259 19 Usual Residence of Decedant | □м 2🙀 ғ | 79 ^Y | rs. | illis Days | Hours Mill. | | 1918 | | | |
| | and w | | 10a. Stata 10b. County | | 10c. City, Town | or Location | | | | | 1 | 0d. Insida City I | Limits |
| | Aaryl | 5 | Maryland Harfo | ~~d | | | | | | | | 1 Yes 2 | |
| | 1he / | Director | 10e. Street end Number | i d | rore | st Hi | . Zip Coda | | | 10g. Citizan of V | Afhat Coun | in 2 | |
| | W W | 0 | 504 Kilarney Ct. | | | 101 | . Lip Coda | 21050 | | | | ily i | |
| | leath | era | 11. Marital Status | 12. Was Dacedant I | Evar in U.S. | 13 Was D | acedant of I | 21050 | necify Yas or No | USA 14 Bec | a - Americ | an Indian | |
| | the rest | Funeral | 1 ☐ Navar Married 2 ☑ Married | Armed Forcas? 1 ☐ Yes 2 ☑ N | | Il Yas, | specify Cub | Hispanic Origin? (S en, Mexican, Puari | o Rican, atc.) | Blad | ck, Whita, | | |
| 020 | filed within 72 hours after death with the Maryland Hygiena. ther than "natural", or items 23a or 28a-f show ent, the Medical Examinet must be recitied at | by | 3 ☐ Widowed 4 ☐ Divorced | If Yas, Giva Yaar or Datas: | | 1 □ Ye | s 2 No | Specify: | | Specify | . Wh | ite | |
| Ö | 2 hor | | 15. Decedent's Ed | ucation | 16a. C | ecedant's | Usual Occu | pation | | 16b. Kind of Br | | | |
| 21215-0020 | hin 7 | Completed | (Spacify only highast gra Eiementery/Secondary (0-12) | da completed) Collega (1-4or 5 | 4) | Giva kind o Iifa. DO NO | f work dona OT usa retire | during most of world) | king | | | | |
| | d wil | PO. | Elonionisty/ Joseph Carly (UTE) | 4 | */ | Hom | emakei | 2 | | Own | Home | 3 | |
| Maryland | al Hy orth | Be (| 17. Fathar's Nama (First, Middla, Last) | | | | | 18. Mother's Ner | na (First, Middla, | Maiden Surnam | na) | | |
| <u>a</u> | should be and Mental I marked or umatic eve | To | Raymond (nmn) | Maure | | | | Abbie | Susan | Burdio | k | | |
| an | 2 sho end I Is me | | 19a. Informant's Name/Ralationship (7 | Type, Print) | 19b. I | Mailing Add | lress (Stree | t and Number or Ri | ral Routa Numbe | er, City or Town, | State, Zip | Coda) | |
| | 1 end 2 Health em 27 I | | Wesley C. Frankli | n — Husbai | nd 50 | 4 Kila | arney | Ct., For | est Hill | L, MD 2 | 1050 | | |
| ore | of Herritan | | 20a. Mathod of Disposition | | 20b. Place of C | Disposition cramatory | (Nama of or other pla | ce) | Deta | 20c. Location - | City or To | wn, Slate | |
| altimore, | it. Pages inment of I reant: if ite njury or o | | 1 Burial 2 □ Cramation 3 □ 4 □ Donation 5 □ Other (Specify | | | | | al Cem. | 9-2-97 | Arlingt | on, V | /irginia | a |
| Balt | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heelth and Mental Hygiana. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Mapical Examples must be recitied at ODEs. | | 21. Signature of Funaral Sarvice Licen | saa | | | | ass of Facility McComas | TTT Far | | | | |
| _ | 40240 | | Ally C. M | Comas | | 50 7 | W Broa | adway St. | , Bel Ai | ir, MD | 21014 | | |
| | | | 23a. Pert1. Entar tila disease, or comp shock, or heart leijura. List only | olications that caused ona cause on each lin | tha daath. Do no | anter the | moda of dyl | ng, such as cardia | or raspiratory a | rrest, | | Approximata Interval Batwee | en |
| | Physician /Medical | | Immediate Cause (Final | | | 7. | | | λ. | | ĺ | Onset and Dea | ath |
| | Examiner | | Immediate Causa (Final disaasa or condition rasulting in death) | a. Chronic | Obstr | veti | ve Fo | monar | 1 Dis | ease. | | 10 ye | ars |
| | | <u>-</u> | | | Dua to (or es e co | nsequence | of): | C-1 | | | | | |
| | ted nsit | ulu u | | b. Cong | estive | Hear | 1 | Failure | | | | | |
| IP. | wecu s end el-tra | xai | Sequantially list conditions, if any, leading to immediate causa. Entar Underlying Causa (Disease or Injury | | Dua to (or es e co | nsaquance | ol): | | | | i | | |
| 68760, | icata be executed physician end s the buriel-transit | le: | causa. Entar Undarlying Causa (Disaasa or Injury thet Initiated avants | C | e Ren | | | re | | | i | | |
| 287 | tificata be executed g physician end as the buriel-transit | edical Examiner | rasulting In death) Last | ı | Oue to (or as a co | nsequance | of): | | | | | | |
| | ding ding | 5 | | d | | | | | | | | | |
| Box | eath etter for u | ciar | | | | | | | | | | | |
| 0. | y the | Physician/ | Part II. Other significant conditions co | entributing to death bu | t not rasulting in t | ha underlyi | ng causa gi | van in Part I. | 1 | tobacco use co | | | |
| | v requires that the death cer been signed by the ettendin should be detached for use | by Pt | | | | | | | 1/0 | Yes 2 No | 3 Prot | ebly 4 ☐ Un | known |
| Records, | uiras Sigr Ild be | | | | | | | | 24a. Was | an eutopsy | 24b. Wa | ra autopsy find | dings |
| OS O | v req beel shou | Completed | | | | | | | perfo | rmad? | COR | allabla prior to applation of caus | ise |
| Re | The law sata has t page 2 s | m | | | | | | | | | | deeth? | |
| | | e C | 25. Was case referred to medical | | | | | | | Yas 2□No | 11 |]Yes 2□ No |) |
| 5 | ysician: s certific director, | o B | axeminar? | Hospital: | • • • • • • • • • • • • • • • • • • • | | Oti | nor: | ath (Check only o | | | | |
| ō | Phys rthis aral di | - | 27. Mannar of Death | 28e. Deta of Injur | | | DOA 28c. Inju | 4 LI Nursing F | lome 5 Rasid | danca 8 LIOth how injury occur | |) | |
| 0 | ding F th. After funer | tio | 1 Natural 5 ☐ Panding Invastigation | (Month, Day | Year) Inj | | Wo | rk? IYas 2 ⊡No | | | | | |
| Division of Vital | Attending Physician: ar death. ector: After this certific by the funeral director, | fica | 3 ☐ Suicida 6 ☐ Could not be | | ry - At homa, fam | | | 121-1-12 | 28f. Location (S | Street and Numb | er or Rura | l Routa Number | er, |
| S | after Dire | Certification: | 4 Homicide | building, afc | . (Specify) | , | , | | City or Tov | vn, Stata) | | | |
| | apita hours neral y fille | | 29a. Certifiar Cartifying Phy | alcian: To the best o | l my knowladge, o | death occur | red at tha ti | ma, data and place | , and due to the | ceuse(s) end ma | innar es st | ated. | |
| | To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Att completely filled in by the fun | edical | (Check only 2 Medical Exam | Inar: On the basis of and manner sta | axamination and/ | or Invastiga | ition, in my | opinion, daath occu | rred at tha tima, | data and piaca, | and dua to | tha causa(s) | |
| | withii To th | × | 29b. Signetura and titla of cartifier | . / | | | 29c. Licens | | 4 | 29d. Dete signe | | | |
| | | | 1.les | han | | } | DE | 5012 | | AUGUST | 7 25 | ,1997 | 7 |
| | 0, | | 30. Name and eddrass of person who d | omplated causa of da | ath (Item 23a) (T | ype, Print) | | // - | | | | | |
| | * | | 1 J.Ke | vin Lync. | h mp. | 2 | Nort | L Ave. | Be/Ail | - md | , 21 | 014 | |
| | Sta | te | 31. Data liled (Month, Day, Year) AUG 26 1997 | 321 Registre | r's Signatus | all | | a | | | | | |
| | Registr | ar | AUG Z U 1337 | Jean Down | | | | | | | | | |

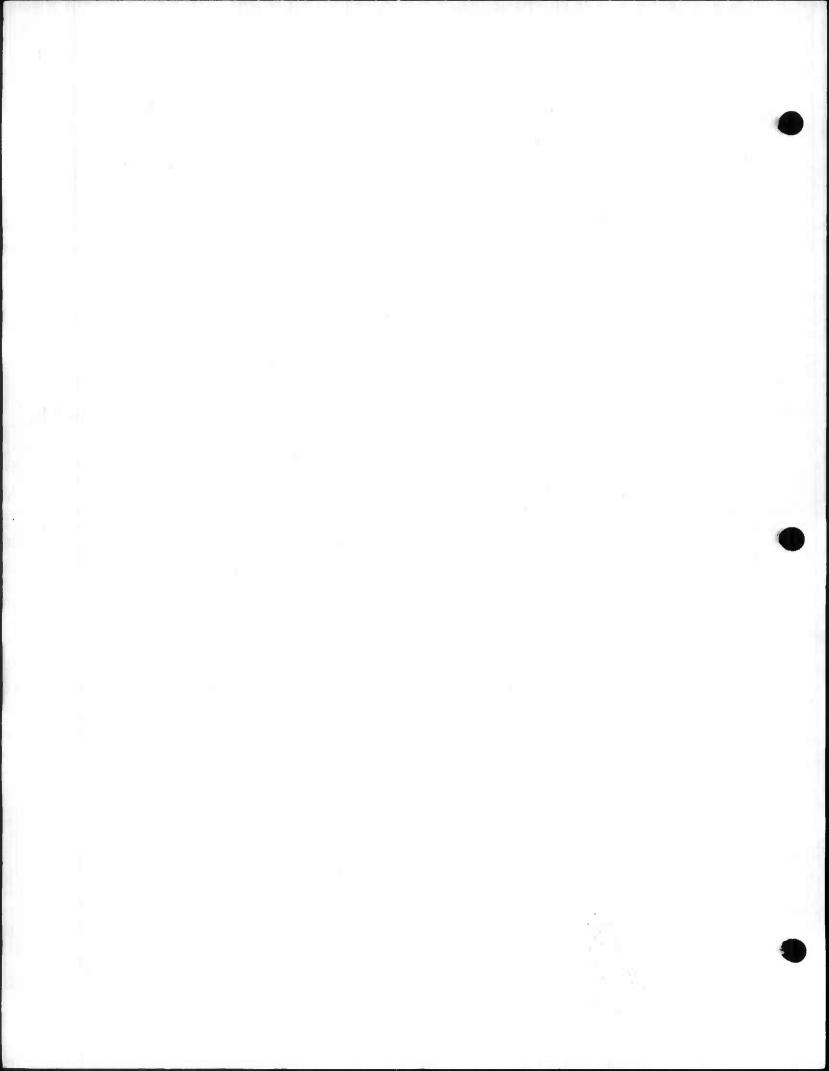
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Month Year Н. Joseph Freeman 23,1997 12:53am August /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Sacurity Number 6. Sax 1 ☐ M 2 ☐ F If Undar 1 Yaar if Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Aug. 21, 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Days Hours 026-01-4348 83 Yrs. Director 1914New York Usual Rasidance of Decadant the Maryland 10a. Stata 10b. County 10c. City, Town or Location r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 10d. Insida City Limits XXYas 2□No Director Maryland Montgomery Chevy Chase 10e. Straat and Number 10f. Zip Coda 10g. Citizan of What Country? death with 5555 Friendship Blvd. 20815 U.S.A. 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☑ Yas 2 ☐ No If Yas, Giva Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican indian, Black, Whita, atc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours efter hand of health and Mental Hygiene. and if filem 27 is marked other than "natural; or ite ury or other traumatic event, its marked. 1 Navar Married 2 Marriad Baltimore, Maryland 21215-0020 1 ☐ Yas 2√ No Specify: by Specify: White 3 Widowad 4 Divorced Yaar or Datas: WWII Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Dacadant's Education 16b. Kind of Business/Industry (Specify only highast grada complated) U.S. Census Elamantary/Sacondary (0-12) Collaga (1-4or 5+) Economist Bureau 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maldan Surnama) Be Jeanette Guterman Harry Feingold 19a. informani's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 5555 Friendship Blvd. Chevy Chase, MD 20815 Alison Freeman 20b. Placa of Disposition (Nama of cemetary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 🂢 Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) permit. Page Department of Important: If any injury or Metropolitan Crematory 8/25/97 Alexandria, VA 21. Signature of Funarai Sarvice 22. Nama and Addrass of Facility Ives-Pearson Funeral Homes 2847 Wilson Blvd. Arlington, 22201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrasi, shock, or heart failure. List only one cause on each line. Approximata intarval Batween Onsat and Death **Physician** /Medical Immediata Causa (Finai disaasa or condition rasulting in daath) eardiec **Examiner** errest Dua to (or as a consaquance of): Examiner Dua to (or as a consequence of): The law requires that the death certificate be executed burial-transit Sequantially list conditions, if any, laading to Immadiata causa. Entar Undarlying Causa (Diseasa or injury that initiated avants rasulting in daath) Last Box 68760. attending physician Physiclan/Medical obstructive lung diseize the Dua to (or as a consequence of): use as Po P.O. Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3⊠Probably 4 Unknown unkrown. Records, þ 8 page 2 should Completed 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? peen complation of causa of death? certificate 1 Yas 2 No 1 Yas 28 No of Vital Attending Physician: director Be 25. Was casa rafarred to medical 28. Placa of Death (Check only ona) axaminar Hospital: 1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 9 Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No this funeral 28a. Data of injury (Month, Day Year) 27. Mannar of Daath Certification: 28b. Tima of 28c. injury at Work? 28d. Dascribe how injury occurred Division After 5 Panding invastigation 1 Natural spital or Attendin lours efter death. neral Director: Afr filled in by the fur 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, straai, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida To the Hospital or within 24 hours eff To the Funeral Di completely filled in 1 Certifyl g Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.
2 Medical Examiner: On the basts of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. Medical 29a, Cartifiar (Check only one) 29b. Signatura and till 29c. Licansa number 29d. Data signed (Month, Day, Yaar) EJEOB EDG] 08/23/97 DIIAZZ, MZ on who completed causa of death (Itam 23a) (Type, Print) 5530 Wisconsin Ave. Chevy 30. Nama and add e of o Chase, TEROW M SHARL 20815 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State AUG 27 Julia Davidson

Registrar



Funeral

Director

nem 27 is marked other then "natural", or items 23s or 28s-f show other traumstic event, the Medical Examiner must be notified at

the Maryland

death

filed within 72 hours after Hygiene.

Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Flores Rosa Aminta Salvador AUG. 1997 18, 10:30AM /Medicai 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 418- NORTH SUMMIT AVENUE APT. #2 GAITHERSBURG MONTGOMERY If Under 1 Year if Under 24 Hrs. 5. Social Security Number 8. Data of Birth Month, Day, Year) May 23, 1961 9. Birthplace (Stata or Foraign El Salvador 7. Age (In yrs. lest birthday) Days 1□M 2☑F 219-27-4143 36 Usual Residence of Decedeni 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☑ Yes 2 ☐ No Directo Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g, Citizan of What Country? 418 North Summit Avenue, #2 20877 El Salvador Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, White, elc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 KMarried tv Yes 2□No Specify: El Salvadorian 2 No þ Specify: Hispanic 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Cashier Fast Food Restaurant 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Pedro DeJesus Garciaguirre Maria Antonia Flores 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Jesus Angel Flores / Brother 418 North Summit Ave., #2, Gaithersburg, MD 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata ***Burial 2 Cramation 3 Removal from State El Salvador San Rafael Orient Cem. 9/8/97 San Rafael, 4 Donation 5 □ Other (Specify) 21. Signatury of Funeral Service Linesee 22. Name and Addrass of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final autin and disease or condition resulting in death) Due to (or as a consequence ot) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence ot): Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 25. Was case reterred to medical examiner?

ACAYes 2□ No 28. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa AResidence 8 Other (Specify) 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of

Physician /Medical Examiner **burial-transit** certificate be axecuted

and

physician a

950

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked othe any Injury or other traumatic event.

Physician/Medical by Completed Be 2

Certification:

Medical

2

Box 68760. 0 P.O. signed by t Records, peed paga 2 certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funaral

| 29a. | Certifier (Check only one) |
|------|----------------------------------|
| 29b. | Signature ar |

1 Natural

2 Accident

3 Suicide

4 Homloide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

6 Could not be determined

5 Pending Investigation

8-19-97 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

0730 M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Subject cut

Shabbar and

281. Location (Street and Number or Rural Route Number, City or Town, State) Sumit Ne APT

AUG. 20, 1997

XIXMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. Licansa numbar

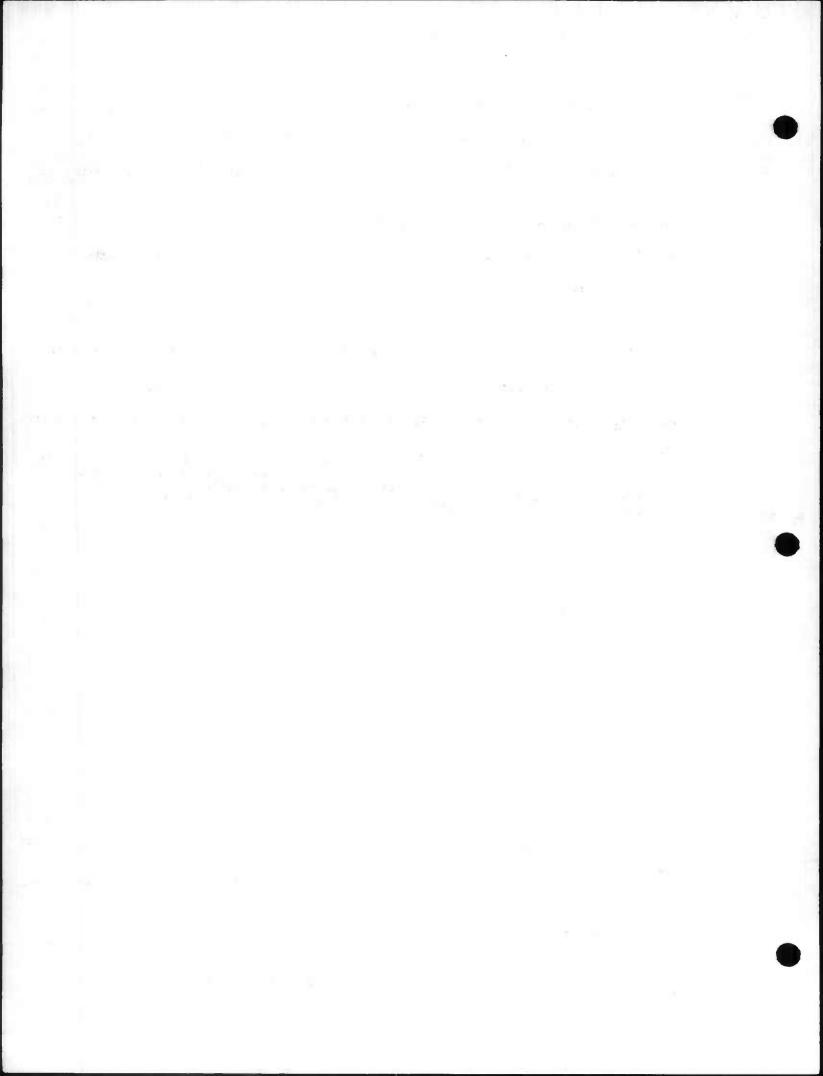
30. Name and address of person who completed cause of death (item 23a) (Type, Print) lowid

gower

111 Penn Street, Baltimore, Maryland 21201

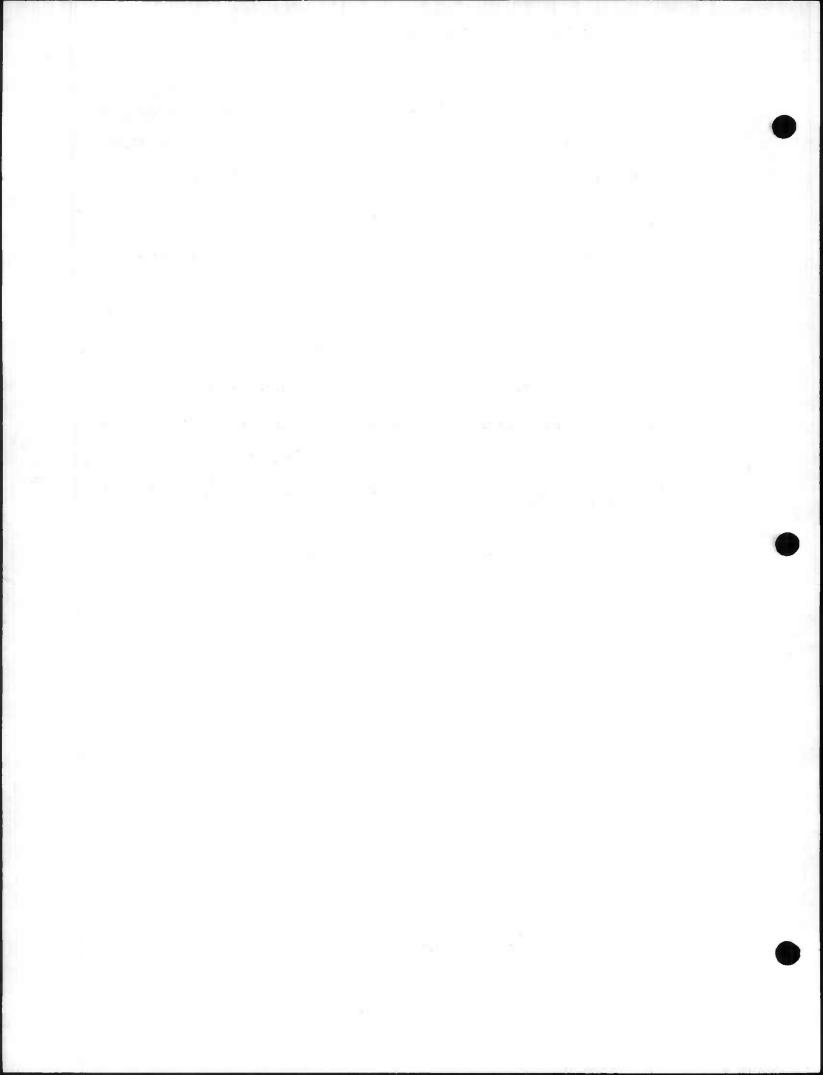
O.C.M.E

State Registrar 32. Register's Signature



State of Maryland / Department of Health and Mental Hygiene 97 27 153

| _ | | | | | | | | Certific | cate of | Death | | Reg. N | 10. | huo | 7100 |
|---------------------|--|---------------|---|--------------------|-------------------------|---------------|----------------------------------|----------------|---------------|-------------------------------------|--|----------------------|----------------|----------------|---|
| | Physic | an | Decedent's Name (First, Middle | e, Last) | | | | | | | 2. Data of 0 Month | | Day | Year | 3. Tim f th |
| ı | Physici /Medi | | Frederick | D. | F | itz | patrick | | | | Augus | | , 199 | | 7:55 M |
| | Examir | | 4a. Facility Nama (If not institution | n, <i>give str</i> | raet end nu | m <i>ber)</i> | | | | 4b. City, Town, | or Location of De | ath 4 | lc. County | of Death | |
| | | | 322 Cedar Lar | ie | | | | | | Rockvil | le | M | lontgo | merv | |
| Г | Funerai | | 5. Social Security Number | 6. Sex | | 7. Age | (In yrs. last bir | | nder 1 Year | | Hrs. 8. Date of E. (Month, L. | | | | aca (Steta or Foreign |
| | Director | 1 | 107-26-4813 Usuel Residence of Decedent | 101 | M 2 🗆 F | 62 | | Yrs. | uns Days | riours | June | 1, 1 | 935 | New Y | |
| | dend \$ m | | 10a. State 10b. County | | | | 10c. City, Tow | n or Location |) | | | | | 10 | d. Inside City Limits |
| | Men | tor | Maryland Mont | gomei | ry | | Ro | ckvill | e | | | | | | 1 XYes 2 No |
| | r 28 | Director | 10e. Street and Number | | | | | 10 | f. Zip Code | | | 10g. C | Citizen of W | hat Count | ry? |
| | h wit | | 322 Cedar Lane | | | | | | 20851 | | | Uni | ted S | tates | |
| | dea F | Funeral | 11. Marital Status | 12 | 2. Was Dace Armed Fo | edant E | var in U,S. | 13. Was D | ecedent of | Hispanic Origin | (Specify Yas or Nuarto Rican, etc.) | No- | | - America | |
| 20 | 72 hours after death with the Marylend natural; or items 23a or 28a-f show diest Example must be inclined at | by Fu | 1 Nevar Married 2 Man 3 Widowed 4 Divorced | | 1 Yas | 2 DXNo ve | 0 | | | Specify: | Jarto Hican, etc.) | | Specify: | k, White, e | itc. |
| 9 | hour | | | | Yaar or D | ates: | 100 | Decedents | Harri Oann | | | 105 | Kind of D. | Whit | |
| 15 | n 72 | iete | 15. Deceden (Specify only highe | | | | 168. | Give kind of | of work done | pation during most of ed) | working | 165. | Kind of Bu | siness/Indi | ustry |
| Maryland 21215-0020 | with than | Completed | Elementery/Secondary (0-12) | | College (1 | 1-4or 5+ | | ice Pr | | | | Rei | ntal 1 | March | andise |
| D | Hygi Hygi other | | 17. Father'a Name (First, Middle, | Last) | | | ν. | ice ii | CSTUC | | Name (First, Midd | | | | lanuise |
| lan | entai entai ked c | To Be | John Fitz | patri | ick | | | | | | nanna Mey | | | , | |
| ary. | M M M | - | 19e. Informent's Neme/Relations | | | | 19b | . Mailing Add | iress (Stree | | Rural Route Num | | or Town. | Stete. Zip (| Code) |
| ž | od 2 lith a 27 is | | Roseann R. Fit | | | Jife | 32 | 2 Ceda | r Lan | e Rocks | 7111e M | | | 20851 | |
| re, | F Heart tarm | | 20a. Mathod of Disposition | a paro | | | 20b. Plece of | Disposition | (Neme of | Aug. | Date | - | Location - 0 | | |
| Baltimore, | Page ment o ant: If ury or | | 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S | | moval from | State | Gate | of Hea | ven C | emetery | 28,1997 | Sil | ver S | pring | ,Maryland |
| Ball | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiana. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified an once. | | 21. Signature of Funeral Service | P L | 1110 | ` | M00348 | Rock | ville | Inc., Maryla | Robert A. 300 W. N and 2085 | Pur lont | mphre gomer | y Fun y Ave | neral Home |
| | | | 23a. Part1. Enter the disease, or shock, or heart feilure. List | complica | tions that c | | | | | | | | 005 | | Approximate Interval Between |
| | /Medical Examiner paud per-transit | Examiner | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to Immediate cause. Extern Indextyring | a | Chi | D | ue to (or as a due to (or as a d | consequence | of): | g Diseas | Se | | | | |
| Box 68760, | eath certificeta be executed attending physician and for use es the bunel-transit | Medical | cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last | c | | D | ue to (or as a d | consequança | of): | | | | | | |
| | death e atter ed for u | sicia | Part II. Other significant condition | na contri | buting to de | ath but | not resulting in | tha underly | ing cause di | ven in Part I | 23b. DI | d tobacc | o use con | tribute to | the cause of death? |
| P.O. | res that the de signed by the a be detached (| Physician/ | | | | | | , | | | | | | | ably 4 ☐ Unknown |
| of Vital Records, | requi | Completed by | | | | | | | | 3 | 24a. Wa | is an aut formed? | | avai | ra autopsy findings ilable prior to apletion of causa |
| Re | The lew ata has b paga 2 s | Ĕ | | | | | | | | | 45 | 7. | 2XXV0 | | eath? |
| a | dcian: The | O O | 25. Was case referred to medica | | | | | | | 00 84 4 | | | 347 MO | | Yes 21 No |
| > | | 80 | exeminer? | | spitel: | nnation | t 2 ER/Ou | trationt 3F | DOA Ot | her: 4 Nursin | Deeth (Check only | | 8 Othe | - (Coit- | |
| o | Phys r this erai d | - | 27. Manner of Death | | 28a. Date | of Injury | 28b. 7 | rime of | 28c. Inju | 4 LI NUISIN | 28d. Describe | | | | / |
| O | odling ith. : Afte | tio | 1 Netural 5 Pending 2 Accident Investig | | (Mont | th, Dey | Year) I | njury M | | rk?]Yes 2 ☐ No | | | | | |
| Division | To the Hospital or Attanding I within 24 hours after death. To the Funeral Director: After completely filled in by the funer | ertification: | 3 Suicide 6 Could determ | | 28e. Placa buildir | of Injur | y - At home, fa (Specify) | rm, street, fa | ctory, office | | 28f. Location City or T | | | or or Rurel | Route Number, |
| | pital ours s eral C | O | 29a. Certifier W Cartifyln | a Physic | len. To the | hout of | mu ka awla daa | don'th con- | and at the ti | in a data and at | ece, end due to th | | (a) and man | | |
| | Hos 24 h Fun etaly | edicai | (Check only 2 Medical | Examina | r: On the ba | asis of e | xaminetion an | d/or investiga | ation, in my | me, date end pi opinion, death o | ece, end due to the courred at the time | e ceuse e, date e | nd place, a | nd due to | the cause(a) |
| | To the Hospital within 24 hours To the Funeral completaly filled | M | 29b. Signature and title of certifie | 4 | 1 | orate | | | 29c. Lican | se number | | 29d. D | ata signed | (Month, D | Day, Yeer) |
| | 10 | | Parker | 41, | Mu | A | , M | > | | 6758 | | | | | |
| | (" | | 20 Nome and address of | 7 | | | ~ /-(| 1 | יכע | 0/30 | | Aug | ust 2 | J, 19 | 771 |
| | | | 30. Name and address of person Barry Simon, M | | | | | | #800 | , Chevy | Chase, N | lary | land | 2081 | . 5 |
| | Sta Registr | | 31. Date filed (Month, Day, Yeer) | | | | 's Signeture | | | | | | | | |



State of Maryland / Department of Health and Mental Hygiene

AMEND # 11 cms 8/19/97 AA CO Health Certificate of Death

Annapolis

Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.)

If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year)

June 14, 1952

4b. City, Town, or Location of Deeth

Physician /Medicai **Examiner**

4a. Fecility Name (If not institution, give street end number)

1. Decedent's Neme (First, Middla, Last)

GUNNING

10f. Zip Code

21146

2 Date of Death Month &

4c. County of Death

10g. Citizen of Whet Country?

Specify:

Friedel

16b. Kind of Business/Industry

14. Race - American Indien, Black, White, etc.

White

Anne Arundel

3. Time of Deeth 740

Birthplece (State or Foreign Country)

10d. Inside City Limits

1 Yes 2K No

Maryland

Funerai Director

Director

notified r nust be n therms 72 hours after ò

the Medical Examiner Hygiene. Pages 1 and 2 should be fill ment of Health and Mental H lant; if Nem 27 is marked off nt of Health a If Nem 27 is or other tra

21215-0020

Baltimore, Maryland

Box 68760,

P.O.

Records,

Division of Vital

Physician Examiner

Department of Important: If any injury or

8 certifica 84 Attec Attending. or Attend after death Director:

Funeral þ Completed Elementary/Secondary (0-12) 17. Fether's Neme (First, Middle, Last) Be Jacquelyn Gunning/Mother 20a. Method of Disposition 1 Buriel 2 Cremetion 3 Removal from Stete 4 Donation 5 Othar (Specify) 21. Signeture of Function Service Li-Physician/Medical Be Completed by Manner of Death Natural Accident 3 ☐ Suicide

Certification: To Medical

MICHAEL Anne Arundel Medical Center 5. Sociel Security Number 1 € M 2 □ F 550-90-0680 Usuel Residence of Decedent 10e. Steta 10b. County Anne Arundel 10e. Street end Number 107 St. Andrews Road 11 Marital Status 150 Never Merried 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grede completed)

Coltega (1-4or 5+)

7. Age (In yrs. lest birthdey)

Yrs.

10c. City, Town or Location

Severna Park

45

1 Yes 2 No Specify: 16e. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) Retired - U.S. Army

U.S. Government 18. Mother's Name (First, Middle, Maidan Sumame)

USA

Thomas I. Gunning 19a. Informent's Neme/Retetionship (Type, Print)

12

19b. Mailing Addrass (Straet and Number or Rurel Route Number, City or Town, State, Zip Code)

Jacquelyn Marie

107 St. Andrews Road, Severna Park, MD 20b. Plece of Disposition (Nema of cemetery, crematory or other piece) Arlington National Cem.

21146 Aug. 19 20c. Location - City or Town, Stete Arlington, VA 1997

22. Name end Address of Fecility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Highway, Severna Park, MD 21146 Do not enter the mode of dylng, such es cardiac or respiretory errest,

Approximeta Intervel Between Onset and Deeth

ne Cause (Final

Due to (or es e consaquence of):
HYAER COAGUCABLE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last

Due to (or es e consaguance of):

WITH

BILATERAL CEREBRAL INFARCTION

PRETUHED

Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert i.

ATELECTA

23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Z Yes

24e. Wes en autopsy performed?

26. Plece of Deeth (Check only ona)

24b. Wera eutopsy findings avellable prior to completion of cause of daath?

2 No

1 ☐ Yes No

25. Was case referred to medical 200 1 Yes

5 Pending investigation

6 C Could not be

28a. Dete of Injury (Month, Day Year)

Inpatient 2 ER/Outpetient 3 DOA 28b. Tima of 28c. Injury et Work?

1 TYes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Dascribe how Injury occurred

28f. Location (Straat end Number or Rurel Route Number, City or Town, State)

29a, Certifier

4 C Homicide

Certifying Physician To the best of my knowledge, death occurred at the time, date end piece, and due to the causa(s) and mannar as stated. Modical Examinar: Ob the basis of axaminetion end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) mennar stated.

29c. Licensa number

29b. Signature and title of certifie

Nama and addrass of person who complated causa of daath (ttam 23a) (Type, Print) 968 BESTEATE

D.KRINCINS 31. Dete filed (Month, Day, Year)

AUG 1 9 1997

32. Ragistrer's Signature

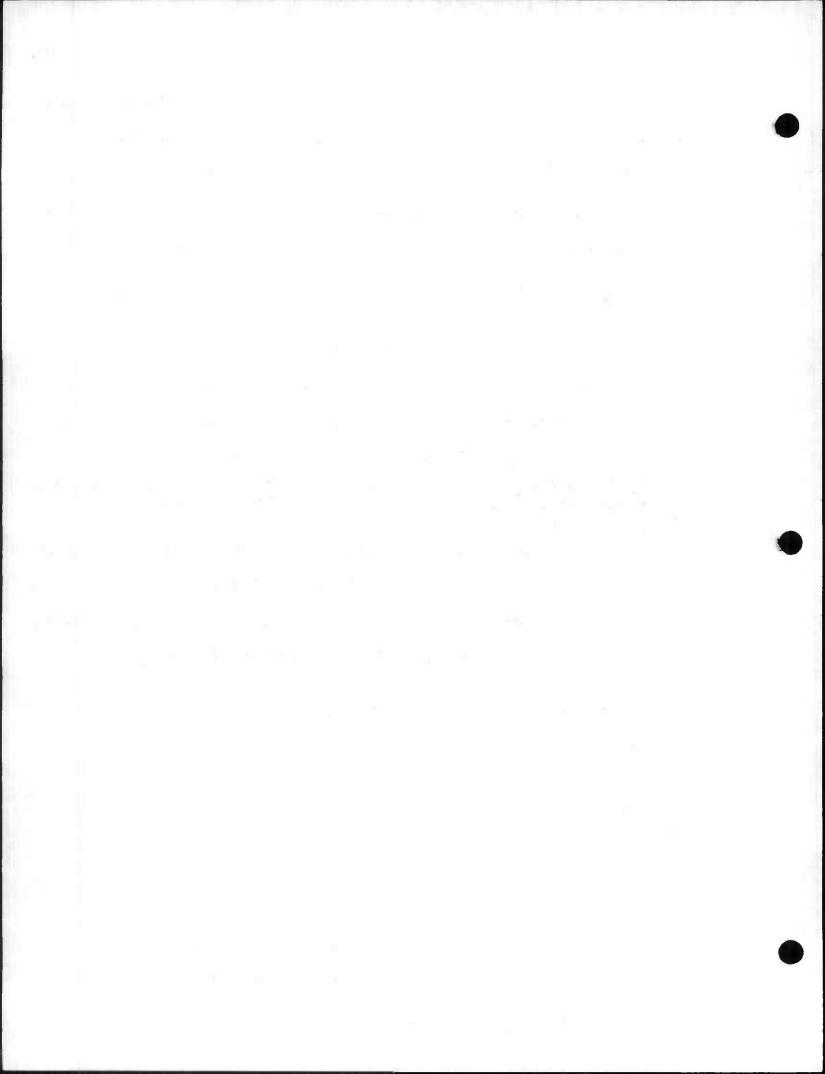
Achie Davidson

28e. Ptace of Injury - At home, farm, street, factory, office building, atc. (Specify)

State Registrar

n 24 hours a Hospital

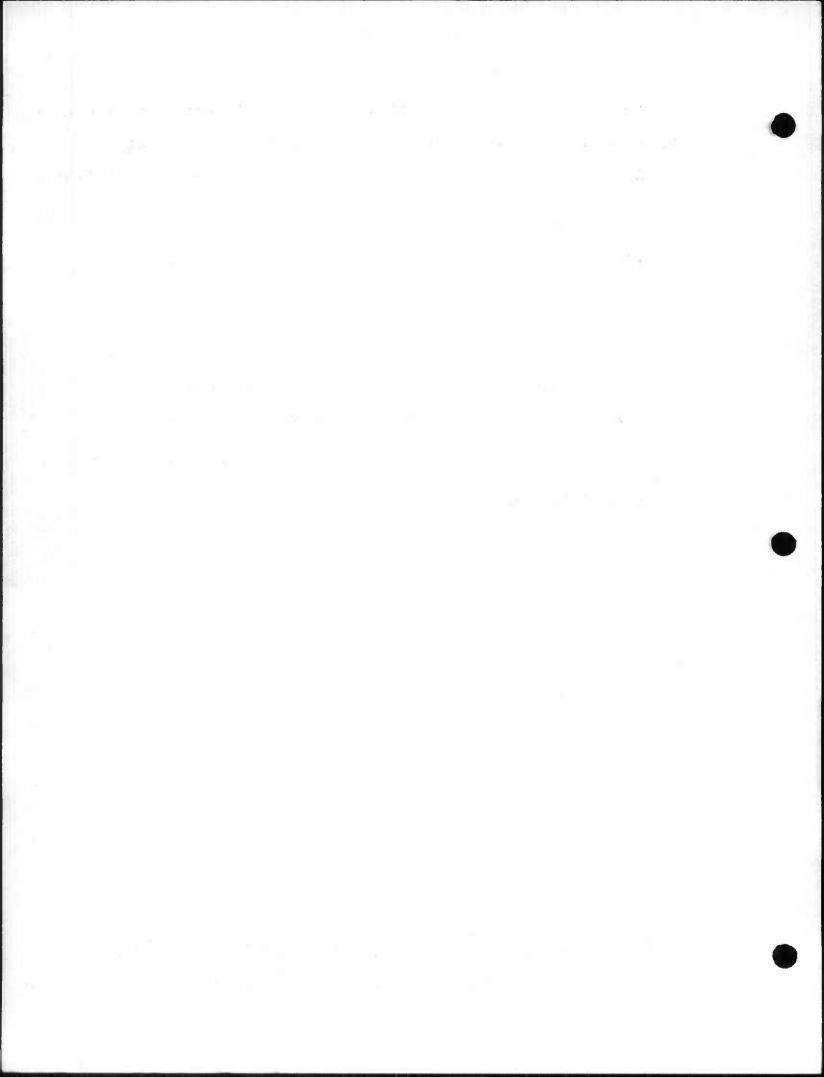
To the To To the Operation 2



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9.7 2.7 1.5.5

| | | | | | State of t | viaryiai | | | ificate of | Death | Mental H | ygiene Reg. No | | 4 | 113 |)) |
|---------------------|--|------------------|---|-------------------------|-----------------------------------|-----------------------------|------------------|---------|--|--|--------------------------------------|-------------------|------------|-----------------------|-----------------------------------|------------|
| | | | 1. Decedent'e Neme (First, | Middle, Li | nst) | | | | | | 2. Dete of D | | | | 3. Tima | of Death |
| | Physic /Medi | | Leonard | | | | Gei | ner | al | | Month Augu: | st 2 | | Year 997 | 1:55 | РМ |
| | Exami | | 4e. Facility Name (If not Inst | itution, gi | ve street end numb | er) | | | | 4b. City, Town, o | | 7 | . County | | 11.00 | 211 |
| | | | Genesis El | der | Care - ! | The F | ines | s | | East | on | | Та | lbot | | |
| | Funeral | | 5. Social Security Number | | Sex 7. | Age (In yrs. | | dey) | If Under 1 Yeer Months Days | | | irth | | | | or Foreign |
| | Director | | 382-07-9604 | | XOXM 2□ F | 77 | Yr | s. | violitis Days | riouis Mil | 8. Dete of B (Month, I Apr. 06 | ,192 | 0 | Mic | plece (Stete http:). Chigai | n |
| | pu , | | Usual Residence of Decede | | | 10- 0 | . T | | At- | | | | | | | |
| | show show | - | 100000000000000000000000000000000000000 | | | | ty, Town o | or Loca | ition | | | | | 1 | 10d. Inside | |
| | death with the Maryland ms 23a or 28a-f show | Funeral Director | | Talb | ot | Ła | ston | | For all 100 | | | | | | 4 1 | s 2 No |
| | E 9 8 | 吉 | 10e. Street end Number | | | | | | 10f. Zip Code | | | 10g. Cit | tizen of W | /het Cour | ntry? | |
| | ath w | ra. | 6100 Dutchman | 's L | | | | | 21601 | | | | SA | | | |
| | her dea | nue | 11. Maritai Status | | 12. Wes Decede Armed Force | s? | ,S. | 13. We | es Decedent of F es, specify Cub | Hispenic Origin? (an, Mexican, Pue | Specify Yes or Norto Rican, etc.) | 0- | | - Americ k, White, | etc. | |
| 20 | within 72 hours after ene. than "natural", or the he Medical Examine | by F | 1 □ Never Merried 2 □ Never M | | 1 XYes 21 | | 1 | 1 🗆 | Yes 2XNo | Specify: | | | | Whi | | |
| 8 | 72 hours "natural", | | | | Yeer or Date | s: | 10. 0 | | | | | 1 400 14 | | | | |
| 15 | n 72 nat | Completed | (Specify only h | edent's E | ducation ede <i>completed)</i> | | (0 | 3ive kk | nt's Usuai Occup nd of work done ONOT use retire | during most of w | orking | 16b. K | and of Bu | siness/In | dustry | |
| 12 | with than | Ĕ | Elementery/Secondary (0- 12th | 12) | College (1-4 | or 5+) | | | trician | ۵, | | C | onst | ruct | ion | |
| P | Hygi Her if | ŭ | 17. Father's Name (First, Mic | ddle, Lasi | ") | | | | OL LOLAII | 18. Mother's Ne | eme (First, Middl | | | | | |
| an | d be entai | To Be | Ernest Wic | | | | | | | | sidy Kwa | | | -, | | |
| Maryland 21215-0020 | shoul mari | 1 | 19a. Informant's Neme/Reia | | | | 19h M | Aeilina | Address (Street | end Number or F | | | | State 7ir | Code1 | |
| Ž | permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. In important; if item 27 is marked other than "natural", or items any Injury or other traumatic event, the Modical Examiner mode. | | John General | - | | | 1080 | 06 1 | Longwood | ds Road, | Easton | MD 2 | 1601 | 0,0,0, | | |
| re, | Hea Hea | | 20a. Method of Disposition | | | 20b. F | Piece of D | isposit | ion (Neme of | ites. | Dete | 20c. L | ocation - | City or To | own, Stete | |
| J10 | age ant o rt: If I | | 1 ☐ Burial 2/C/Crema 4 ☐ Donetion 5 ☐ Oth | | | (e | _ | | tory or other ple ematory | | 8/8/97 | Dow | er, | DF. 1 | 9901 | |
| Baltimore, | permit. Pa Departmen Important: any Injury | | 21. Signature of Puneral Ser | | | cap | 1001 | | | | 1 | | , | | ,,,, | |
| B | Depariment Important International Internati | | 101 SI | 14 |) , | | | | | ss of Facility | | - | 1601 | | | |
| | | | 29a. Parti. Enter the disees | e or con | polications that cause | ed the deet | h Do not | | 6 E. Dov | | Easton | | TOOT | | Approxim | nto |
| | Dhusislan | | 23a. Pura Enter the disees or heart failura. | List only | one ceusa on aacl | n lina. | 00 1101 | Onto | ine mode of dyn | ng, such as caran | ac or respiratory | arrost, | | | Intervat Bo | etween |
| | Physician /Medical | | tmmediete Cause (Final | | Ci (| , , | | | A. | | | | | | | |
| | Examiner | | disease or condition resulting in deeth) | | old cost | - 4 | 1 2 | 200 | echil | ierge | | | | | men | ut |
| Ш | | Je | | | / | Due to (d | or as a cor | nseque | ence of): | | | | | i | men | |
| | b d ansit | Examiner | Seguentially list conditions | | b. 6 cost | Due to /o | or es e cor | 0 | ince of: | ermo | | | | 1 | GN | 10 |
| o, | exec an an rial-tr | EX | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or injury | | | 500 10 (0 | . 00 0 00 | loodec | 1100 017. | | | | | 1 | | |
| 68760, | ificate be executed physician and as the burlat-transit | edical | Ceuse (Disease or injury that initieted events resulting in deeth) Lest | 5 | c | Due to (o | r as a con | eupea | nce of); | | | | _ | | | |
| | E 0 6 | | resulting in deetil) Lest | | | | | -cri_r | | | | | | i | | |
| Box | hat the deeth certif ed by the ettending detached for use a | Physician/N | | | d | | | | | | | | | - 1 | | |
| | 0 0 0 | sici | Part II. Other significant cor | ditions | contributing to death | but not res | uiting in th | ne und | erlying cause gh | ven in Part I. | 23b. D | tobacco | use con | tributs to | the cause | of death? |
| P.0 | requires that the been signed by th hould be detache | h/ | | | | | | | | | 119 | Yes 2 | .□ No | 3 Pro | bably 4[| Unknown |
| | es tha igned be del | by | | | | | | | | | - | | | | | |
| of Vital Records, | v requin | P P | | | | | | | | | 24a. Wa | s an auto | psy | av | ere autopsy ailabie prior | to |
| ecc | 2 S T | ple | | | | | | | | | | | 1 | of | mpletion of death? | cause |
| 8 | 0 - 0 | Completed | | | | | | | | | 1□ | Yes 2 | □ No | 1[| ☐Yes 2(| l No |
| ita | ysician: The | Bec | 25. Was casa raferred to me axaminer? | dical | | | | | | 26. Place of De | eath (Check only | one) | | | | |
| 5 | 5 00 | To | 1 Yas 20 No | | Hospitel: 1 Inpe | atient 2 | ER/Outpa | atient | 3 DOA Ott | ner: 4 Nursing | Home 5 Res | idence | 6 □Othe | er (Specif | (y) | |
| | ter th | | 27. Manner of Death 1 ANetural 5 □ Pe | andina | 28a. Date of In | njury De <i>y, Year)</i> | 28b. Tim Inju | | 28c. Inju | ry at rk? | 28d. Describe | how Inju | ry occurr | ed | | |
| Division | or Attending after death. Director: After in by the fune | Certification: | 2 Accident In | estigatio | 0 8 1 | 191 | ,- | ., | | Yes 2 □ No | | | | | | |
| Š | or Atte | Ħ | 3 ☐ Suicide 6 ☐ Co | ould not be termined | 289. Place of | Injury - At he | ome, ferm | , stree | t, tectory, office | | 28f. Location City or To | (Street er | nd Numbe | er or Aure | I Route Nu | mber, |
| | rs after all Dir | S | | | | | · | | | | | | | | | |
| | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral | edical | 29a. Certifier ↑ Cert | tifying Ph | nysician: To the bearing | st of my kno | wiedge, d | eath o | ccurred et the ti | me, date and piec | e, and due to the | ceuse(s |) end me | nner ss s | teted. | (e) |
| | the thin 2 the phin 2 | | one) | | and manner | stated. | | | | | | | | | | (-) |
| | 5 × 5 00 | Σ | 29b. Signeture end title of ce | rtitier | (1) 1 | | | | 29c. Licens | se number | | 29d. De | te signed | (Month, | Day, Year) | |
| | | | Kalul | VVV | LVVVS | Ja | rool | 2 Ni | 0) | 1901 | 4 | 8 | 5/2 | 1)/ | 7') | |
| | į | | 30. Name and eddress of per | son who | completed ceuse o | f daath (Iten | 1 23a) (Ty | pe, Pri | int) | 300 | | | | 1=0 | , h/ | \ _ |
| | | | KOWERT | 1 | USW. | ONL | 140 | 1 | (1) | 201 | OVER ST | REET | 1 | 11ts | 1Cr, 1711. |) 2160 |
| | Sta | | 31. Dete filed (Month, Day, Y | | 32. Regi | strer's Signa | ture | | | | | | | | | |
| Div | Registr | | AUG | 63 | 1997 | - what | avidson | 1-P | indole | | | | | | | |
| DH | MH 16 Rev 6/9! |) | | | - V | | | - | | | | | | | | |



State of Maryland / Department of Health and Mental Hygiene

| | | | | Cei | rtificate d | of Death | R | g. No. | 4 | .1136 |
|--|---------------------|---|---|-----------------|---|--|---|-------------------------|------------|--|
| Physicia | 30 | 1. Decedent's Neme (First, Middle, Last) | | 1.785 | Phys. C | | 2. Date of Deat Month | | Year | 3. Time of Death |
| /Medic | | Mildred Cooper | | | 91000 | | August 2 | | | 11:10AM |
| Examin | er | 4a. Facility Name (If not institution, give s Physicians Memorial H | | | | 4b. City, Town, or L La Plata | ocation of Death | 4c. County of | | |
| Funeral | | 5. Social Security Number 6. Sex | 7. Age (In yrs. | last birthday) | If Under 1 Ye | ear If Under 24 Hrs. | 8. Date of Birth | Vacri | 9. Birthp | lace (Stete or Foreign |
| Director | | 5/8-01-041/ | IM XIF 9 | 1 Yrs. | Months Da | ys Hours Min. | 8. Date of Birth (Month, Day, NOV . 2 | 7 1905 | Coun | Wash. DC |
| ¥ | | Usual Residence of Decedent 10a. State 10b. County | 10c. Cit | y, Town or Lo | cation | | | | 1/ | 0d. Inside City Limits |
| The day | tor | MD St. M | ary's M | lechan | icsvi | lle | | | | 1□Yes 2 No |
| or 28 | Olrec | 10e. Street and Number | W. S. P. (2) | 1000 | 10f. Zip Coo | | 1 | Og. Citizen of W | | itry? |
| 23a | rail | 36524 Ryceville | | | | 659 | | U.S | | |
| or them | by Funeral Director | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ever In U Armed Forces? 1 ☐ Yes 2 🕱 No If Yes, Give | 1 | | of Hispanic Origin? (Sp Cuban, Mexican, Puert No <i>Specify:</i> | Decity Yes or No- Dican, etc.) | Biack | White, | |
| ratural disal Ex | Completed b | 15. Decedent's Educ (Specify only highest grade | Year or Dates: cation completed) | 16a. Deced | dent's Usuai Oc kind of work do | ccupation one during most of wor tired) | king | 16b. Kind of Bus | siness/inc | dustry |
| than Me | Jumo | Elementery/Secondary (0-12) | Coilege (1-4or 5+) | life. I | Homem | | | н | ome | |
| Hyp. | Be Co | 17. Father's Name (First, Middle, Last) | | | Homem | | ne (First, Middle, M | | | |
| Aenta rked fir ev | To B | Charles Cooper | | | | Soph | nie Coop | per | | |
| la ma | | 19a. Intormant's Name/Relationship (Type | pe, Print) | | | reet and Number or Ru eville Ro | | | | |
| Health arm 27 ther t | | Douglas C. Gord 20a. Method of Disposition | on/Son | | | | | 20c. Location - | | |
| ant: If Its | | 1 ☑ Buriel 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) | | | sition (Name of the restriction of the restriction) with the material of the restriction | Park 8/ | | | | |
| Depart Import any inj | | 21. Signature of Funeral Service License | 011 | | | T=ECHOLS | | | | 1C. |
| | | 23a. Part 1. Enter the disease, or complishock, or heart tailure. List only on | | | | ox 567 La dying, such as cardiac | | | 46 | Approximate Interval Between |
| hysician | | SHOCK, OF Heart failure, List only on | | | | | | | | Onset and Death |
| /Medical Examiner | 6 | Immediate Cause (Final disease or condition resulting in death) | SEP | StS | | | | | 1 | 4-5 DAYS |
| | - | | Due to (d | or es e consec | quence ot): | | | | | |
| sician end bunal-transit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (c | or as a consec | quence ot): | | | | | |
| ng physician es the buria | edical | Cause (Diseasa or injury that initiated events resulting in death) Last | Due to (o | er as a conseq | uence of): | | | ded | | |
| ending | ~ | d | I | | | | | | | |
| he ett | Physician/ | Part II. Other significant conditions con | tributing to death but not res | ulting in the u | nderlying cause | given In Part I. | 23b. Did to | bacco usa con | tributa to | the cause of death? |
| signed by the ettendir be detached for use | by Phy | ACUTE | RENAL | FA | ILU | RE | 1 🗆 Y | 8 2 No | 3 Prot | bably 4 Unknown |
| has been sig | Completed t | | | | | | 24a. Was a perform | n autopsy ned? | ava | ere autopsy findings allable prior to impletion of cause deeth? |
| 4 6 | Com | | | | | | 1 🗆 Y | s 2 No | 10 | Yes 2□No |
| certificate ha | Be | 25. Was case referred to medical examiner? | | | | | ith (Check only on | (e) | | |
| | To. | 1 ☐ Yes 2 No | | ER/Outpatier | | | ome 5 Reside | | | у) |
| th. : After | tion | 1 Neturei 5 Pending 2 Accident investigation | 28a. Dete of Injury (Month, Dey Year) | Injury | | Injury at Work? 1 ☐ Yes 2 ☐ No | 200. 2000100 110 | ow injury occurr | , | |
| within 24 hours effect death. To the Funeral Director: After this completely filled in by the funeral d | Certification: | 3 Suicide 6 Could not be determined | 28e. Piace of Injury - At h building, etc. (Specif | ome, tarm, str | eet, tactory, off | ice | 28f. Location (St City or Town | reet and Number, Stete) | or Rura | al Route Number, |
| neral (| | 29a. Certifier Certifying Phys | iclan: To the best of my kno | wledge, deeti | n occurred et th | e time, date end plece | , and due to the c | ause(s) and ma | nner as s | tated. |
| in 24 t he Fu | edicai | (Check only 2 Medical Examir one) | er: On the basis of examina and menner steted. | ition and/or in | vestigation, in r | ny opinion, death occu | rred at the time, d | ate end place, a | nd due to | the cause(s) |
| Tot | Z | 29b. Signature and title of certifier | angandle | 01 | | cense number | 2 | 9d. Date signed | | |
| 1 10 | | | U | | | 26064 | | 8-2 | -1- | 1/ |
| | | 30. Name and address of person who co Vidysagar Anmangandla | | | | .Box 282 Char | lotte Hall | ,Maryland | 2062 | 2 |
| Sta Registr | | 31. Date flied (Month, Day, Year) 6/1/2 9 199 | 32. Registrar's Signary | ture Reso | Call | | | | | |

Division of Vital Records, P.O. Box 68760,

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| | Ple | State 2 | , and / Dep | | f Health | and N | | | gible. | 27157 |
|-----------------------|-------------------------------------|-----------------------------|------------------------|----------------------------|---------------------------|-----------------|----------------------------------|----------|--------------|----------------------|
| Dhusisian | 1. Decedent's Nema (First, Mid | die, Last) | | | | | 2. Data of Deat Month | h Dev | Yaar | 3. Tima of Deeth |
| Physician /Medical | Lenita G | Gorre | 11 | | | | August | | 1997 | 2:51 AM |
| Examiner | 4a. Facility Name (If not instituti | on, giva street and number) | | | 4b. City, To | wn, or L | ocation of Death | 4c. Cour | nty of Deeth | |
| | Citizens N | ursing Home | | | Havre | de | Grace | На | rford | |
| Funeral | 5. Social Security Number | 6. Sex 7. Age | (In yrs. lest birthday |) If Under 1 Y Months D | ear If Under ays Hours | 24 Hrs. Min. | 8. Date of Birth (Month, Day, | | 9. Birthp | place (State or Fore |

Director

Funeral

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Completed

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itam 27 is marked other than "natural", or items 23s or 28s-f show other traumetic event, the Medical Examiner must be notified at permit. Pages 1 and 2 should be filed within 72 hours effer deeth v Depertment of Health and Mantal Hygiene. Important: If item 27 is marked other than "natural", or items 23e eny Injury or other traumatic event, the Medical Exercise 2008.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

attending physician and for use es the burial-transit signed by the peed page 2 hes funeral director.

24 To the F within 2

certificate be executed Hospital or Attending Physician: 24 hours efter deeth. Funeral Director: After this certific

Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medical ð Completed Be ٩ Certification: edical

te or Foreian 213-01-0058 96 Usual Basidance of Dacadant 10a. Stata 10c. City, Town or Location 10d. Insida City Limits 1X Yes 2 □ No Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizan of Whet Country? 505 Congress Avenue 21078 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Raca - Amarican Indian, Black, Whita, atc. 11. Marital Stetus 1 ☐ Yes 2 🔀 No If Yas, Giva 1 Never Merriad 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Manufacturing Co. 17. Fether's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Meiden Sumeme) William Howard Gorrell Fannie Worthington 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Mrs. Dorothy G. Hall - Niece 300 Commerce Street, Havre de Grace, MD 21078 20b. Placa of Disposition (Neme of camatery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Data 1 X Burlal 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Angel Hill Cemetery 8/26/97 Havre de Grace, MD 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility Mitchell-Smith Funeral Home, Havre de Grace, MD 21078-21078-3197 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such es cardiac or raspiratory errast, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onsat and Death Immedieta Ceuse (Final disease or condition resulting in deeth) 210 Yrs Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaase or Injury that Initiated events resulting In death) Last Due to (or as e consequence of) Due to (or as e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 W6 3 Probably 4 Unknown

1 Yes 1 ☐ Yas 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 JH6 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Data of Injury (Month, Dey Year) 27. Mannar of Deeth 28b. Time of 28c. Injury et Work? 28d. Dascribe how Injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicida 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At home, farm, straat, factory, offica building, etc. (Specify) 4 Homicida

1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. 29a. Cartifian (Check only one)

MUS

29b. Signeture and title of certifier hisam

3260

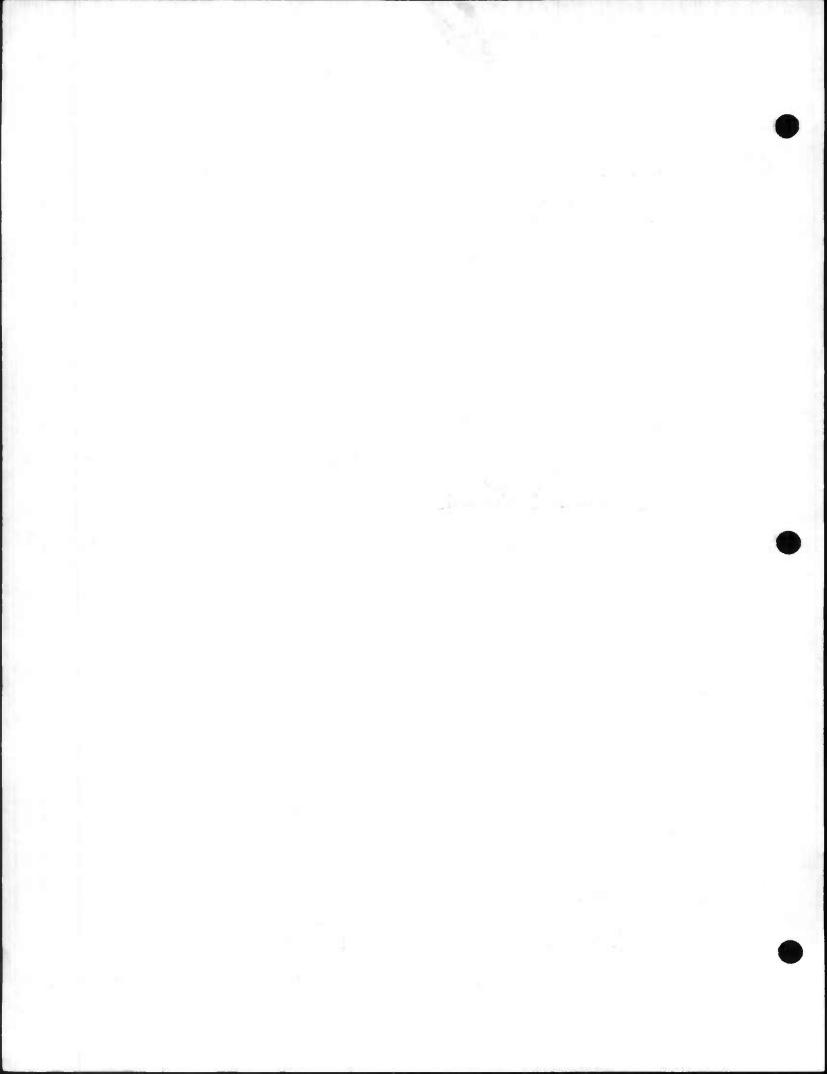
29d. Date signed (Month, Dey, Year)

24a. Was an autopsy

24b. Were autopsy findings available prior to completion of cause of daath?

30. Name end eddrass of person who completed causa of death (Itam 23a) (Typa, Print) 703 Revolution St Harre De Grace MSQ1078 (ammedia Meltrain Ms.

State Registrar



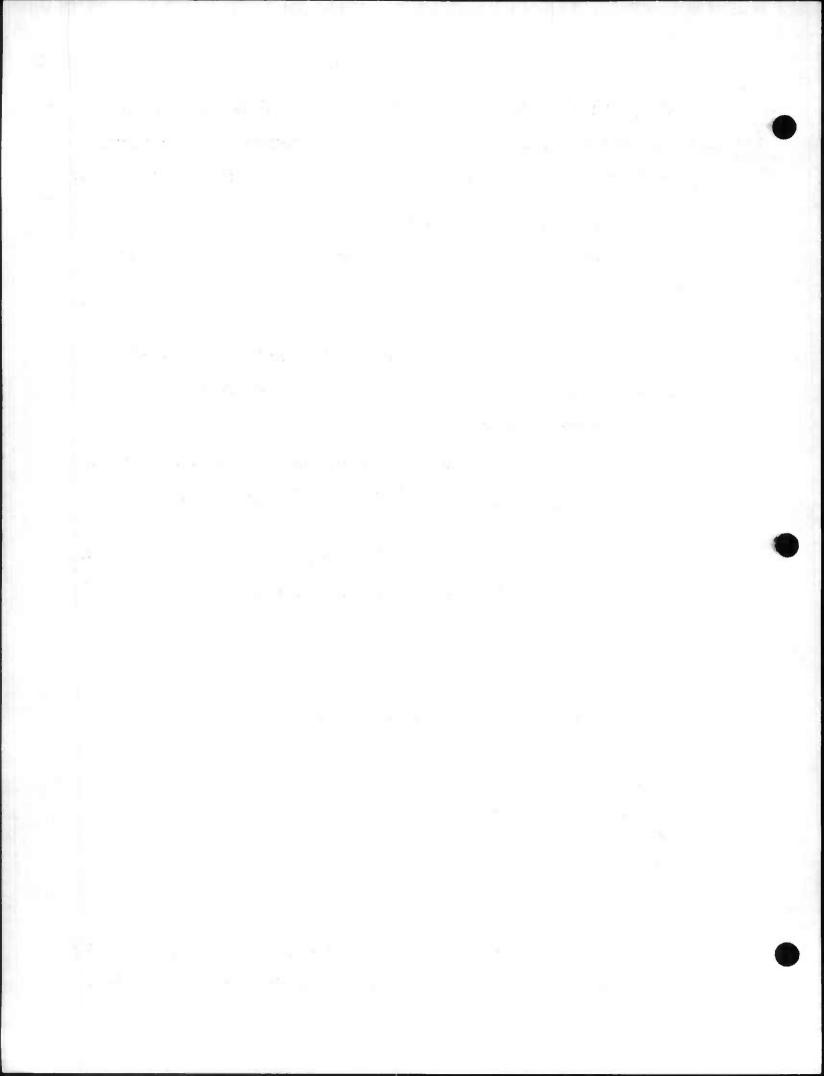
State of Maryland / Department of Health and Mental Hygiene 97 27 | 58

| Thaylor Jean Grammont, III August 11, Toy 1939 73 7:35 Results Near grant manufaction grass served and manufaction produced in the served and manufaction in the served and served forms and manufaction produced in the served and manufaction in the ser | | | • | Certificate of L | Death | Reg. No. | 4/100 |
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| Prince George's Hospital Center Social State of Control Social S | Dhuaini | an | | | | | 3. Time of Deeth |
| ## Facility New Prince George's Mosphile Country (See and See Country Observed Country Number) ## Facility New Prince George's Mosphile Country Number | | | Thaylor Jean Grammont, I | I I | Augu | ist 11, 1997 | 7:35 PM |
| Social Social Social Funders Number Social Social Social Social Number Social Social Social Number Social Number Number | | | | | b. City, Town, or Location of | Deeth 4c. County of I | Deeth |
| None On the Purple Place Programment of December 1 (Secretary Place Plac | | | | | Cheverly | Prince | George's |
| The State 10c. County 10c. Silver Spring 10c. Silver Spring 10c. Spring | 4.00 | | None ¹¤™ 2□ F 0 | Months Days | Hours Min. 26 Augu | of Birth th, Day, Year) St 11, 1997 | Birthplace (State or Foreign Country) Maryland |
| 17 Februar's Name (First, Middle, Lest) 18 Mother's Name (Fi | pus * | | | v. Town or Location | | | 10d Incido City I leito |
| 17. Februr's Name (First, Middle, Lest) 18. Mother's Name (First, Mi | sho | 5 | | | | | 1 ☐ Yes 2 No |
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| 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last) 19. Mother's Name (First, Mi | with po | | | | | | |
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| 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last) 19. Mother's Name (First, Middle, Mariden Name) 19. Mother | no 7 | plet | (Specify only highest grade completed) | (Give kind of work done do life. DO NOT use retired) | uring most of working | 1001711100100111 | osa modotty |
| Physician Middical Examiner Physician Middical Examiner Physi | d with | E | | None | | Nor | ne . |
| Physician Middical Examiner Physician Middical Examiner Physi | othe othe | Se C | 17. Fether's Neme (First, Middle, Last) | | 18. Mother's Name (First, M | | |
| Physician Middical Examiner Physician Middical Examiner Physi | Aenta Aenta rked tice | 0 | Thaylor Jean Grammont, Jr. | | Joan E. | Goodwin | |
| Physician Middical Examiner Physician Middical Examiner Physi | am a | | 19e. Informent's Neme/Reletionship (Type, Print) | 19b. Meiling Address (Street e. | nd Number or Rurel Route N | Number, City or Town, Ste | te, Zip Code) |
| Physician Middical Examiner Physician Middical Examiner Physi | elth 27 is 27 is | | Joan E. Grammont Mother | 626 Sonata Way. | . Silver Spri | ng. Marvland | 20901 |
| Physician Middical Examiner Physician Middical Examiner Physi | of He ltem | | 20e. Method of Disposition 20b. P | laca of Disposition (Neme of | Dete | | |
| Physician Middical Examiner Physician Middical Examiner Physi | Pege nt: If ry or | | 1 □ Burlei 2 ☑ Cremation 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) | sapeake Cremato | orv 8-29-97 | Beltsville | e. Maryland |
| Physician // Middical Examiner of the disease, or complication find caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest. Index of heart flower interval feeth of the second of control or sealing in deeth). The second of the second of control or sealing in deeth) in the second of control or sealing in deeth). The second of the second of control or sealing in deeth) is a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 24b. Were autoppy for death of | orta | 1 | | 22. Name end Address | s of Fecility | | |
| Physician Modical Examiner Physician Modical Examiner | De Per | | VIII / / ///// | Rapp Funera | al Services. | P.A. | |
| Due to (or es e consequence of): Due to (or es e consequence of): Due to (or es e consequence of): | executed in and riel-transit | Examiner | Due to (or Sequentially list conditions, if any, leading to immediate | rus a consequence of): | | | |
| Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 1 No. 3 Probably 4 1 | ortificate be ing physicie e es the bu | Medicai | that initiated events resulting in death) Lest | es e consequenca of): | | | |
| 24e. Wes an autopsy performed? 24e. Wes an autopsy performed? 24e. Wes an autopsy performed? 25. Was case referred to medical examiner? 1 Yes 2 Info 25. Was case referred to medical examiner? 1 Yes 2 Info 26. Plece of Death (Check only one) 27. Menner of Death 28e. Dete of Injury at Work? 27. Menner of Death 28e. Dete of Injury at Work? 28e. Location (Street and Number or Rural Route Number of N | 0 0 0 | SICI | Part If. Other significant conditions contributing to death but not resu | Ifting In the underlying cause give | n In Pert I. 23b. | Did tobacco use contrit | oute to the cause of death |
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| The state of the s | clan | | exeminer? | | | only one) | |
| Duilding, etc. (Specify) 29e. Certifier (Check only one) 29e. Certifier (Check only one) 29e. Signeture end title of cartifier 29b. Signeture end ditteed cause of death (flem 23e) (Type, Print) 30. Nems end address of person who completed cause of death (flem 23e) (Type, Print) 29c. License number 29d. Date signed (Month, Dey, Year) | hys his al di | - } | 27. Menner of Deeth 1 Death 28e. Dete of Injury (Month, Day Year) | 28b. Time of fnjury Work? | et 28d. Desc | | Specify) |
| 29e. Certifier (Check only one) 29e. Certifier (Check only one) 29e. License number 29e. License number 29e. Date signed (Month, Day, Year) | 5 2 2 5 | Certifica | 3 Sulcide 6 Could not be determined 28e. Pleca of Injury - At ho | me, ferm, street, factory, office | 28f. Local | | r Rural Route Number, |
| Janua L. June, ND D47737 828 97 30. Neme end address of person who completed cause of deeth (Nem 23e) (Type, Print) RINCE GEORGE'S HOSTIM GOVER, 3001 Hospital Drive, Cheverly, Maryland | • Hospi • Funer letely fill | | (Check only 2 Medical Examiner: On the basis of examineti | vledge, deeth occurred et the time ion end/or Investigation, In my opi | e, dete end piece, and due to nion, deeth occurred et the | o the cause(s) end manne time, deta and place, and | r as stated. due to the cause(s) |
| Janua L. John D. D. A. 7737 828 97 30. Nema end address of person who completed cause of deeth (flem 23e) (Type, Print) VRINCE GEORGE'S HOSTIM GOVER, 3001 Hospital Drive, Cheverly, Maryland | Vithir To th | | 29b. Signeture end title of cartifier | 29c. License | number | 29d. Date signed (M | Ionth, Day, Year) |
| PRINCE GEORGE'S HOSPITAL GOTER, 3001 Hospital Drive, Cheverly, Maryland | | | Laye L. Quine | UD DE | 7777 | 8/2.5 | 2/97 |
| VRINCE GEORGE'S HOSTITAL GOVER, 3001 Hospital Drive, Cheverly, Maryland | | - | 30. Neme and address of person who completed cause of death from | 23e) (Type, Print) | | 000 | 101 |
| | | | PRINCE GEOLUPP'S HOSPIT | M- 150 YPFR | 3001 Hospital D | nnings, M.D. | Maryland 2078 |
| State 31. Dete filed (Month, Day, Year) AUG 2 9 1997 Aug Day down - Rondere | Stat | e | 31. Dete filed (Month, Day, Year) 32. Registrar's Signat | | | THE STREET IN | rai y laila 20/0 |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 0.7

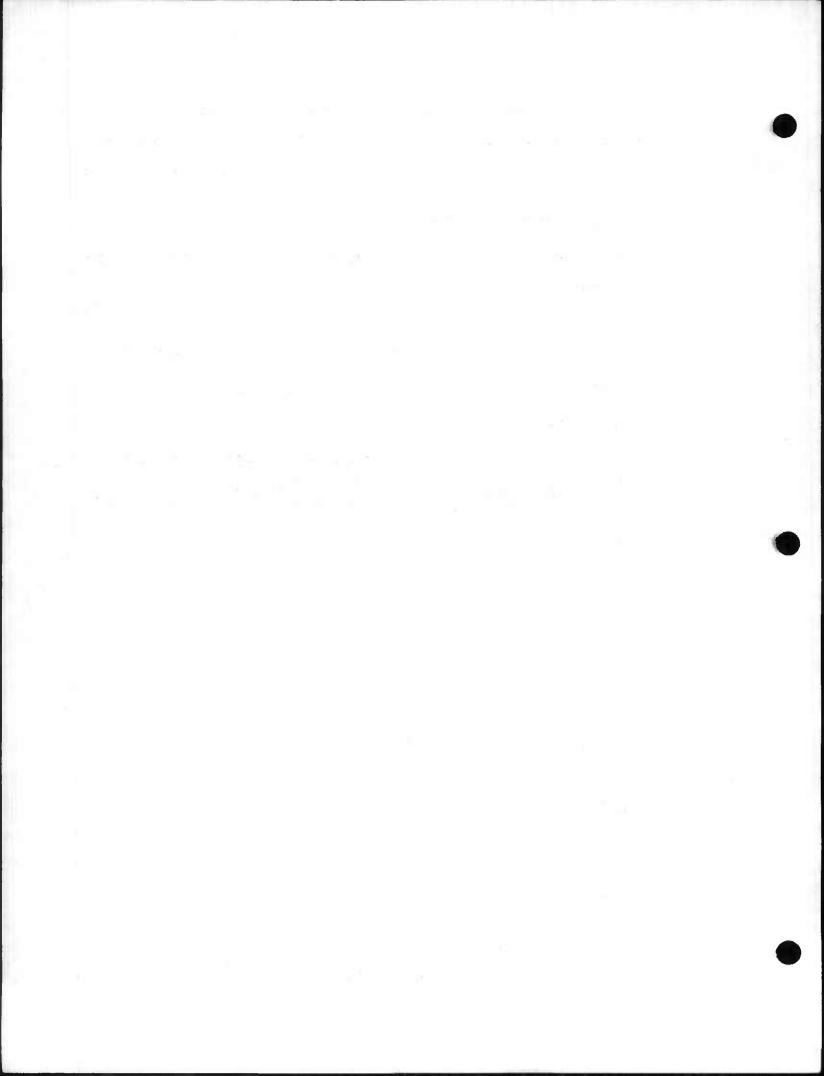
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|---------------------|--|----------------|---|--|-----------------------------------|----------------------|---|--|---|-------------------|--------------------------|-------------------------------|--|
| | Physic /Medi | | 1. Decedent's Name (First, Middle, WALTER | ANGI | EL C | 30 | LOST | TEIN | 2. Date of De Month | ST | 26 | Yeer 1997 | 3. Time of Death 6:15 AM |
| J. | Exami | ner | 48 Facility Neme (If not institution, | give street and number |) | | 4 | tb. City, Town, or L | | | c. County | | |
| | | - 2 | GROVE ADVENTIST H | | // b b | 4- 1 | If Under 1 Yeer | ROCKVILL If Under 24 Hrs. | T | | MONIC | SOMER! | |
| | Funeral Director | | 5. Social Security Number 582-96-0609 Usual Residence of Decedent | . Sex 7. A | ge (In yrs. last birtho 76 Yrs | A | Months Days | Hours Min. | 8. Date of Bir (Month, Da April 2 | V. Year | 921 | 9. Birthple Countr Engl | ace (State or Foreign ny) and |
| | yland | | 10a. Stete 10b. County | | 10c. City, Town o | or Loca | tion | | | | | 10 | d. Inside City Limits |
| | with the Maryland a or 28a-f show | Director | Maryland Montgo | mery | Rockvil | le | | | | | | | Ç∏ Yes 2 No |
| | with t | Dir | 10e. Street end Number | | | | 10f. Zip Code | . 0 | | | | /hat Countr | |
| | seath w | Funeral | 102 Emily Drive | 12. Was Decedent | Ever in U.S. | 13. Wa | 2085 s Decedent of H | U lispanic Origin? (Sp | ecify Yes or No | | | Kingd | |
| Maryland 21215-0020 | d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 Is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examinar I has be inclined at | | 1 Never Married 2 Married 3 Widowed 4 Divorced | Armed Forces | ? No | If Y | es, specify Cuba Yes 2\ No | Specify: | Ricen, etc.) | | | k, White, et | |
| 5-0 | "naturel", | Completed by | 15. Decedent's (Specify only highest s | Education | 16a. Do | eceden | it's Usual Occup | ation during most of work d) | ina | 16b. F | Cind of Bu | siness/indu | |
| 121 | within ene. | mple | Elementary/Secondary (0-12) | College (1-4or | 5+) | | | | | _ | | | |
| d 2 | filed within Hygiene. ther than " | | 12 17. Fether's Name (First, Middle, La | st) 4 | Cont | tro I | System | S Enginee | | | | ring | Firm |
| lan | should be filed and Mental Hygi marked other imatic event, I | To Be | David Goldste | | | | | Hannah | | | Jumann | 6/ | |
| any | should be filed with and Mental Hygiene. Is marked other than aumatic event, the M | - | 19a. Informant's Name/Relationship | | 19b. N | Aailing A | Address (Street | and Number or Rui | | | or Town, | State, Zip (| Code) |
| | CENE | | Beryl Patricia | Goldstein | Sa | ame | as 10 | | | | | | |
| ore | 8 5 2 0 | | 20a. Method of Disposition 1 ☑ Burlel 2 ☐ Cremation 3 | ☐Removal from State | 20b. Place of D cemetery, | ispositi cremat | on (Name of tory or other plac | ce) | Date | 20c. L | ocation - | City or Tow | m, State |
| altimore, | rtman rtant: njury | | 4 Donation 5 □ Other (Spe | cify) | Parklaw | | emorial | | | | kvill | le, Ma | aryland |
| Bal | permit. Pages Department of Important: If it any injury or once. | | 21. Signature of Funeral Service Lic | Dol | | | | ss of Facility al Servic venue, Si | | | g, ME | 209 | 10 |
| | | | 23a. Part I. Enter the disease, or co shock, or heart failure. List on | mplications that cause ly one cause on each I | d the death. Do not ine. | enter t | the mode of dyin | g, such es cardiac | or respiretory a | rrest, | | | Approximate Interval Between Onset and Death |
| ř | Physician /Medical Examiner | | Immediate Cause (Final disease or condition resulting in death) | · As | piration | P | neumin | ia | | | | | Pays |
| | 200 | Jer | | 1+1 | Due to (or as a cor | | nce of): Vascinlar | r Diseas | | | | 10 | Veces |
| | cata be asscuted physician and s tha burial-transit | Examiner | Sequentially list conditions, if any, leading to immediate | b. A 1/1/6 | Due to (or es a cor | | 1 | נאפניט | | | _ | | John |
| 60, | be axe cian a burial- | | Cause (Disease or Injury | C | | | | | | | | | |
| 68760, | ficata be axecuted physician and is tha burial-transit | edicai | that initiated events resulting in death) Last | | Due to (or as a con | nsequer | nce of): | | | | | | |
| Box | eath certifi attanding I for use as | M/m | | d | | | | | | _ | | | |
| | death ne atta ed for | sicia | Part II. Other significant conditions | contributing to death to | out not resulting in th | ne unde | erlying cause give | en in Part I. | 23b. Did | tobacc | o use con | tribute to 1 | the cause of death? |
| P.0 | res that the de signed by the a be detached t | Physician/M | Irchemic heart | dience | 1.5 | ania | 1 0000 | | 1 🗆 | Yes | 2 No | 3 Probe | ably 4 Unknown |
| ds, | signe d be d | t by | 1) CHEMIC HOUSE | (4.)CM3C | See 1 | 1 | phenn | 14.42 | 0.40 11/10 | | 1 | 24h Was | o autoney findings |
| of Vital Records, | law requires that tha death certi as been signed by the attanding a 2 should be detached for use a | Completed | Hypertension | _ | Sa | cral | deent: | tins | 24a. Was | en auto ormed? | opsy | com | re autopsy findings ilable prior to appletion of ceuse |
| Re | Tha law ata has paga 2 | omp | Gastroesuphageal 1 | C. C. | | | | | 10 | Voc S | No | | eeth? Yes 2 🕅 No |
| ita | ysician: Tha i is cartificata ha director, paga | Be C | 25. Was case referred to medical | LETILY A.SELS | ę | | | 26. Place of Deet | | | (B) 140 | 10 | 105 21Д 110 |
| 1 | Physicia this car al direc | To B | examiner? | Hospital: 1 Inpati | ent 2 ER/Outpa | atient | 3 DOA Oth | | | | 8 Othe | r (Specify) | |
| | al or Attending Physician: s aftar daath. N Director: Aftar this cartification by the funaral director, | | 27. Menner of Death 1 ☑ Netural 5 ☑ Pending | 28a. Date of Inju (Month, Da | ury 28b. Tim ly Year) Inju | | 28c. Injun Wor | | 28d. Describe | how inju | ry occurr | bed | |
| Division | daath daath stor: / | cat | 2 ☐ Accident Investigat 3 ☐ Suicide 6 ☐ Could not | be con Diagram | jury - At home, farm | ctroot | | Yes 2 □ No | 28f Location / | Stroot a | nd Numbe | er or Purel | Route Number. |
| Div | X # = C | Certification: | 4 ☐ Homicide determine | building, e | ic. (Specify) | , 50 000 | , ractory, onice | | City or To | | | or or maran | riodio reamber, |
| | To the Hospital or At within 24 hours aftar of To the Funeral Direct complately filled in by | edical C | 29e. Certifier 12 Certifying I (Check only one) 2 Medical Ex | Phyalcian: To the best aminer: On the basis of end manner st | of examinetion end/o | leath oc or Inves | ccurred at the tin tigetion, in my o | ne, date and place, plnion, death occur | and due to the red at the time, | cause(s | s) and mai d place, a | nner as sta and due to t | ted. the cause(s) |
| | To th To th comp | W | 29b. Signature end title of certifier | | | | 29c. License | e number | | 29d. Da | ate signed | (Month, D | ay, Year) |
| | 1 | | Bigy O. John | mio. | | | D-19 | 1042 | | Ang | ust 7 | 26, 19 | 97 |
| | 1 | | 30. Name and eddress of person who BYRL P. JO WHID | o completed cause of | death (Item 23a) (Ty | rpe, Pri | nt) | Gaithers | Burg, M | aryli | mod | 2087 | 9 |
| | Sta Registr | | 31. Dete filed (Month, Day, Year) AUG 2 7 | 32. Regist | rar's Signature | | | | , | | | | |
| | | | | U | | | | | | | | | |

DHMH 16 Rev 6/95



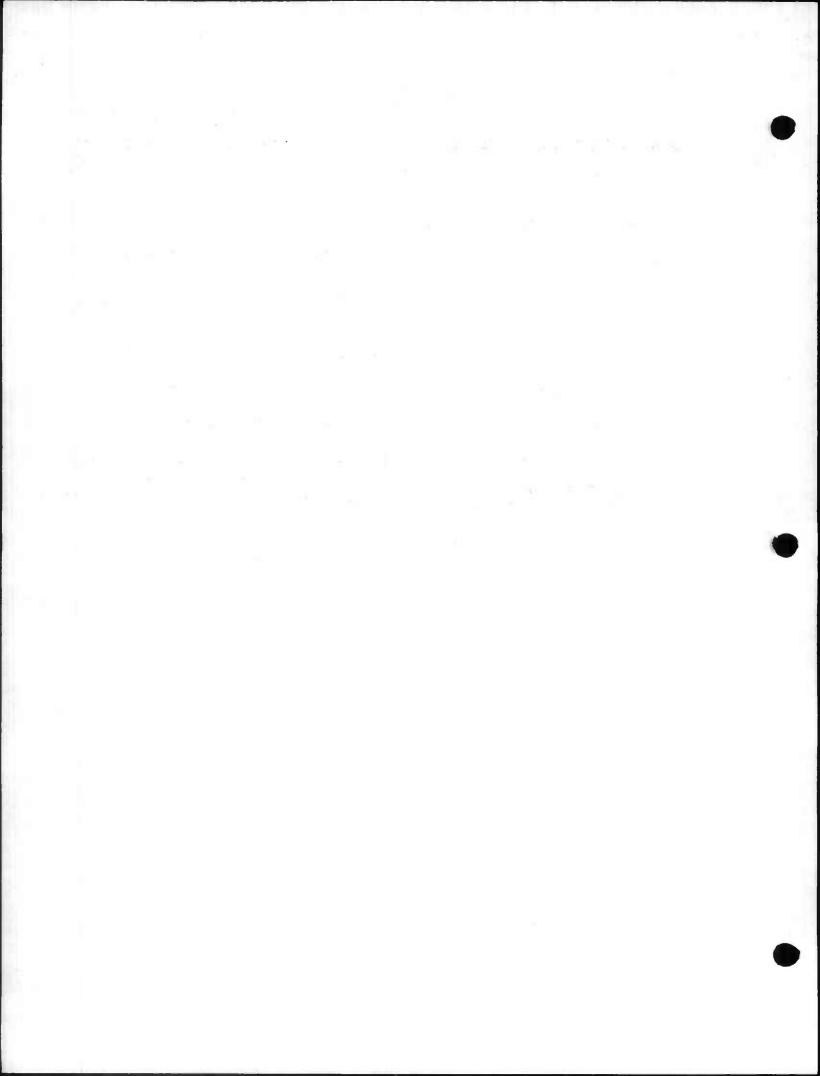
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0.7

| | | | | State of N | | Department of I Certificate of | | | eg. No. | 1 2 | 1160 |
|------------|--|----------------|---|--|------------------------|--|--|---|------------------------------------|---------------------------------|----------------------------------|
| | Physic | | 1. Decedant's Nama (First, Mide | | RKLEY | GLE | | 2. Data of Deat Month | th Day | Yaar | 3. Tima of Death 6:35 Am |
| | /Medi Examir | | 4a. Facility Nama (If not institution | on, giva street and numbe | r) | GZE | 4b. City, Town, or Le | Pugues 7 | 4c. County | of Death | 6.33 AM |
| 7 | LXaiiii | ici | Washington Ad | | | | Takoma Pa | ark | | tgome | cv |
| Н | Funeral | | 5. Social Sacurity Number | | Aga (In yrs. last birt | thday) If Undar 1 Yaar | | | וטויו | | |
| | Director | | 218-18-8318 | 1 5 7M 2□ F | | Yrs. Months Days | Hours Min. | 6. Data of Birth (Month, Day, June 2, | 1924 | Virg | a (Stata or Foraign) inia |
| | yland | | Usual Rasidance of Decedant 10a. Stata 10b. Count | у | 10c. City, Towr | n or Location | | | | 10d. | Insida City Limits |
| | ath with the Marylar 23a or 28a-f show | Ş | Maryland Prin | ce George's | Glenn | Dale | | | | | 1 Yas 2 XNo |
| | 1 th | Directo | 10e. Street and Number | | | 10f, Zip Coda | | 10 | 0g. Citizan of V | Vhat Country | ? |
| | h wil | a D | 9922 Martin | Avenue | | 20769 | 9 | | United | State | S |
| | deal deal | Funeral | 11. Marital Status | 12. Was Dacedan | t Evar In U,S. | 13. Was Dacedant of If Yas, specify Cut | | ecity Yas or No- | 14. Race | e - Amarican | Indian, |
| 5-0020 | 72 hours after death with the Maryland naturel', or items 23s or 28s-f show | by Fu | 1 Navar Married 2 Ma 3 Widowed 4 Divorce | Yas Giva | No | 1 ☐ Yas 2 ☒ No | | Hican, atc.) | Specify | blac | |
| 0 | 72 hours "natural", | Completed | 15. Deceda | nt's Education | 16a. | Decedant's Usual Occu | pation | | 16b. Kind of Bu | | |
| 215 | S 5 | ple | (Specify only high: Elemantary/Secondary (0-12) | ast grada completad) Collega (1-4o | | (Giva kind of work done lifa. DO NOT usa ratire | during most of work | ing | | | |
| 2121 | d withir giene. or then | E O | 6 | Collega (1-40) | 34) | Laborer | | | Constr | uction | |
| Pu | al Hygi other | Be | 17. Fathar's Nama (First, Middle | , Last) | | | 18. Mothar's Name | a (First, Middla, A | Aaidan Sumam | a) | |
| Maryland | ges 1 and 2 should be filed with to f Health and Mental Hygiene. If item 27 is marked other then or other traumatic event, trails | To | Task Glenn | | | | Unavail | able | | | |
| a | and and a me | | 19a. informant's Name/Ralation | ship (Type, Print) | 19b. | Mailing Addrass (Stree | | | City or Town, | Stata, Zip Co | oda) |
| | and and n 27 | | Wilhelmina J. | Glenn | | Same as 10 | | | | | |
| ore | of H of H fiten | | 20a. Mathod of Disposition 1 ☐ Burial 2 🂢 Cramation | 2 Demousi from Stat | | Disposition (Nama of y, cramatory or other pla | ace) | Data 2 | 20c. Location - | City or Town | , Stata |
| E | Pag ment ant: h | | 4 Donation 5 Other (| | | eake Cremat | tory 8 | -25-97 E | Beltsvi | lle, M | laryland |
| Baltimore, | permit. Pages 1 and 2 st Department of Health and Important: If tiem 27 Is n sny Injury or other traun once. | | 21. Signatura of Funaral Sarvice | Ul Ka | 00 | Rapp Funer | | | | | |
| 1 | | | 23a. Part1. Entar tha disaasa, o | or complications that caus | ad the death. Do n | 933 Gist A | Avenue, Si | lver Spr | ring, M | D 2091 | Oproximata |
| | Dhualalan | | shock, or haart failura. Lis | t only ona causa on aach | lina. | of anial tha mode of dy | ing, such as cardiac (| or raspiratory orre | 331, | In | tarval Batween |
| 7 | /Medical | | Immediata Causa (Final disaasa or condition | · Urc | SEPS | 315 | | | | on | reday |
| | Examiner | - | rasulting in death) | | Dua to (or as a c | consequence of): | | | | | 1 |
| | nsit | Examiner | | b. 145/ | 1RATI | ON PA | IEU MO. | NIA | | 0 | neday |
| | icete be executed physician and s the burial-transit | Exa | Sequantially list conditions, if any, laading to Immadiata causa. Entar Undarlying Causa (Disaase or injury | 2001 | Dua to (or as a c | consaquance of): | | | | | 2 . 6 |
| 68760, | sicial b buri | | Causa (Disaase or injury that initiated avants | O. DEH | 100 | 411014 | | | | OV | e day |
| .89 | ficet pphy se the | edical | rasulting in death) Last | | Dua to (or as a c | onsequanca ot): | | | | | |
| Box | beath certific attending p | Ž | | d | | | | | | | |
| m | d for | cia | Part II. Other significant conditi | lone contributing to dooth | but not requiting in | the underlying sever of | iven in Deat I | 22h Dida | | anih ran an ah | e cause of death? |
| P.0 | that the death cered by the attendin | Physician/M | | ons contributing to death | 2 1 | tha undanying causa gr | van in Pan I. | | s 2 No | | ly 4 Unknown |
| | requires that the death certificete be executed seen signed by the attending physician and hould be deteched for use as the bunal-transi | by P | Viabete | , mell | 1-40 | | | | 2010 | 3 Probab | ay 4 Dankilowii |
| Records, | v require been sig should b | | 60-1-0 | · Ledi | 0 | bleed | | 24a. Was ar | n autopsy | 24b. Wara | autopsy findings bla prior to |
| 00 | 20 00 | plet | aus (so E | un SM | ial i | o leed | | parform | nao? | comp of das | letion of causa |
| | 0 - 0 | Completed | Demen | 1ja. | | | | 1□ Ya | s 2X No | 1 🗆 Y | V |
| of Vital | ician: The certificate rector, pag | 0 | 25. Was casa rafarred to medical | • | | | 26. Place of Deatl | | | , | 2010 |
| > | E 10 TO | To B | axaminar? 1 ☐ Yas 2 1 No | Hospital: | tiant 2 ER/Out | tpatient 3 DOA Ot | har | ma 5 □ Rasida | | ar (Specify) | |
| | ding Phys h. After this funeral di | | 27. Manner of Death | 28a. Data of Inj | | ima of 28c. Inju | | 28d. Dascribe ho | | | |
| Division | Attending For death. ector: After by the funer | atio | 1 Natural 5 ☐ Pandi 2 ☐ Accidant Invast | ing (Month, Di tigation | ay Yaar) In | | Yas 2 No | | | | |
| Vis | after death. Director: A | Hick | 3 ☐ Suicida 6 ☐ Could 4 ☐ Homicida datarr | not be nined 28a. Placa of Ir | njury - At homa, far | rm, streat, factory, office | | 28f. Location (Str | | er or Rural R | outa Number, |
| | s after | Certification: | 4 Hornicida | building, a | atc. (Specify) | | | City or Town | , Stata) | | |
| | UN To the Hospital or Attant within 24 hours after deat To the Funeral Director: completely filled in by the | edical (| 29a. Cartifiar (Check only one) | ng Physician: To the best Examiner: On the basis and manners | of axamination and | daath occurred at tha ti | ma, data and place, opinion, daath occurr | and dua to tha ca ed at tha tima, da | iusa(s) and ma ata and place, a | nnar as stata and dua to the | d. a cause(s) |
| | o the | Me | 29b. Signature and little of certific | | - T- | 29c. Lican | sa number | 29 | 9d. Data signed | (Month, Day | y, Year) |
| | 3 | |) Ke | 2,1 | | D19 | 609 | 0 | 8.25 | .97 | |
| | | | 30. Nama and addrash of pareor | who completed seuse of | death (Item 23c) (| | | | | , | |
| | | | 20. Nama and addrasts of person | TULI | 350 3 | Type, Print) PERRY S | PREET | MT.K | PAINI | ERM | 1)20712 |
| H | Sta | te | 31. Data filed (Month, Pay, Year | 32. Ragis | Par's Signature | | | | | -)- | |
| | Registr | | AUG 2 | المراجع المجاري | who Davidson | n-Handell | | | | | |



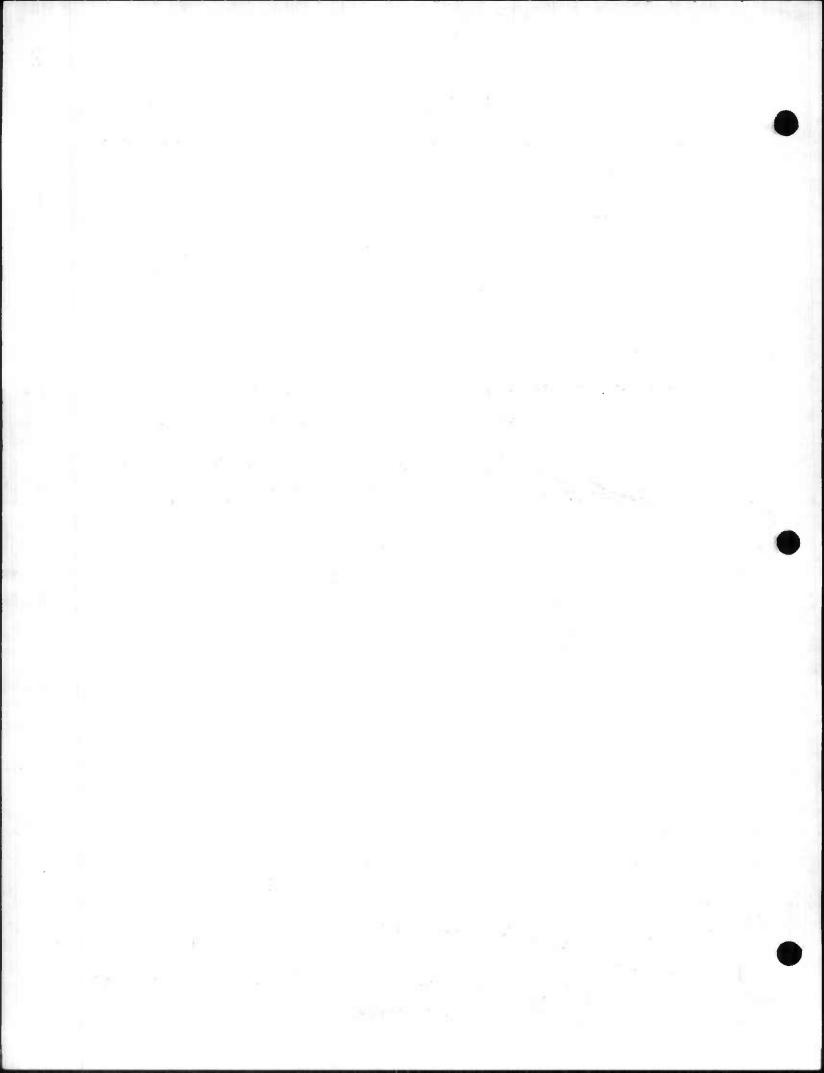
State of Maryland / Department of Health and Mental Hygiene 97 27 | 6 |

| | | | | | Certific | ate of | Death | | Re | g. No. | | |
|---|-------------------------------------|---|--|-------------------------------|--|-----------------------|---|-----------------|---|--|---------------|---|
| Physici /Media | | 1. Decedent'e Neme (First, Middle, Li Frances | M. | | erson | | | À | ete of Deeth Jonth | Day 3, 1 | 997 | 3. Time of Death 0350 |
| Examir | | 4a. Facility Name (If not institution, gi SHADY GROVE ADVE | | | | | | wn, or Location | n di-Death | 4c. County | of Deeth | ERV |
| Funeral Director | | 5. Sociel Security Number 6. 339-05-0325 | | ge (In yrs. last bi | rthday) If Ur Yrs. Mont | der 1 Year hs Deys | | 24 Hrs. R D | ete of Birth Month, Day, | | 9. Birtho | lece (Stete or Fore try) .nois |
| Sa-f show | To Be Completed by Funeral Director | Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Montgomery Gaithersburg | | | | | | | | | | 0d. Inside City Lim |
| th with the | | 10e. Street and Number 22 Timber Rock Ro | | 10f. Zip Code 20878 | | | | | 10g. Citizen of Whet Country? United States | | | |
| a within 72 hours after death with the Menfend liene. Than "natural", or flems 23a or 28a-f show the Medeal Exercipe frout be notified a | | 11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced | 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☒ No if Yes, Give Year or Detes: | | Wes Decedent of Hispenic Origin? (Specify Yes or If Yes, specify Cuben, Mexican, Puerto Rican, etc.) □ Yes 2 ☑ No Specify: | | | | es or No- , etc.) | No- 14. Rece - American Indien, Black, White, etc. Specify: White | | |
| within ene. than | | 15. Decedent's E (Specify only highest gr Elementery/Secondary (0-12) | ducation ade completed) College (1-40) | | 16e. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Housewife | | | t of working | 1 | 16b. Kind of Business/Industry Own Home idle, Meiden Surneme) Petrini | | |
| be filed d other event, | | 17. Fether's Neme (First, Middle, Last George Ceruti | | | | | 18. Mother's Neme (First, Mid Madalene | | | | | |
| nd 2 slith a 27 ia | | 19e. Informent's Neme/Reletionship Rathy Rokos, Date | Type, Print) | 22 | Timber | Rock | Rd., | Gaithe | ersbur | g, MD | 2087 | 8 |
| permit. Pages 1 a Department of Her important: if item any injury or othe | | 20b. Method of Disposition 20b. Place of Disposition (Name of cametery, cremetory or other place) 4 Donation 5 Other (Specify) 21. Senature of Functor Service Licensee 20b. Place of Disposition (Name of cametery, cremetory or other place) Holy Sepulchre Cemetery 8 22. Name and Address of Facility | | | | | | | 20c. Location - City or Town, Stete 7/97 Oak Lawn, Illinois EVol Funeral Home | | | |
| Physician /Medical | | 23a. Pert1. Enter the diseal e, or conshock, or heer feiture. List only | philations thet cause one ceuse on each | ed the death. Do line. | | | | | | | rg, N | D 20877 Approximate interval Between Onset and Deeth |
| The law requires thet the death ele hes been signed by the atter page 2 should be detached for u | n/Medical Examiner | Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest | b | Due to (or es e | consequence | of): of): | | | | | | |
| | Physician | Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. | | | | | | | 23b. Did tobacco use contribute to the cause of death 1 □ Yes 2 □ No 3 □ Probably 4 ☑ Unknow | | | |
| | Se Completed by | | | | | _ | | 2 | 24e. Wes an perform | autopsy ed? | 600 | re autopsy finding slleble prior to apletion of cause death? |
| | | 25. Wes case referred to medical | | | | | 26. Piece | of Deeth (Che | 1 ☐ Yes | | 10 | Yes 2□ No |
| ding Physic h. After this c funeral dire | ation: To B | examiner? 1 Yes 2 No 27. Megner of Deeth 1 Neturel 5 Pending Investigatio | igation M 1 Yes 2 No | | | | | | |) | | |
| ital or Attendins of the death all Director: / | Certification: | 3 Suicide 4 Homicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, efc. (Specify) 28f. Location (Street end Number or Rurel Route Num City or Town, Stete) | | | | | | | | | Route Number, | |
| To the Hospital or At within 24 hours efter of To the Funeral Direct completely filled in by | edical | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner es stated. 2 Medical Exeminer: On the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner es stated. 2 Medical Exeminer: On the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner es stated. 3 Medical Exeminer: On the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner es stated. 3 medical Exeminer: On the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner es stated. 4 medical Exeminer: On the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner es stated. 5 medical Exeminer: On the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner es stated. 5 medical Exeminer: On the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner es stated. 5 medical Exeminer: On the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner es stated. 5 medical Exeminer: On the best of my knowledge, deeth occurred et the time, determiner end to the cause(s) and manner es stated. | | | | | | | | ated. the cause(s) | | |
| S S S S S S S S S S S S S S S S S S S | M | 29b. Signature end title of certifier | John | ~ | | 29c. Licens | | | | d. Date signe | 4 . | |
| , , | | 30. Neme end eddress of person who | completed cause of | deeth (Item 23e) | (Type, Print) | 200 | 685 | 0. 1 | | agus | M D | 3, 1597 |
| Sta | te | 31. Date filed (Month, Dey, Yeer) | 1007 32. Hogis | Page Signature What Davids | Very | 02 ₂ | N III | 629 | Wh | 6 c401 | In | 0 009 |



State of Maryland / Department of Health and Mental Hygiene 0.7

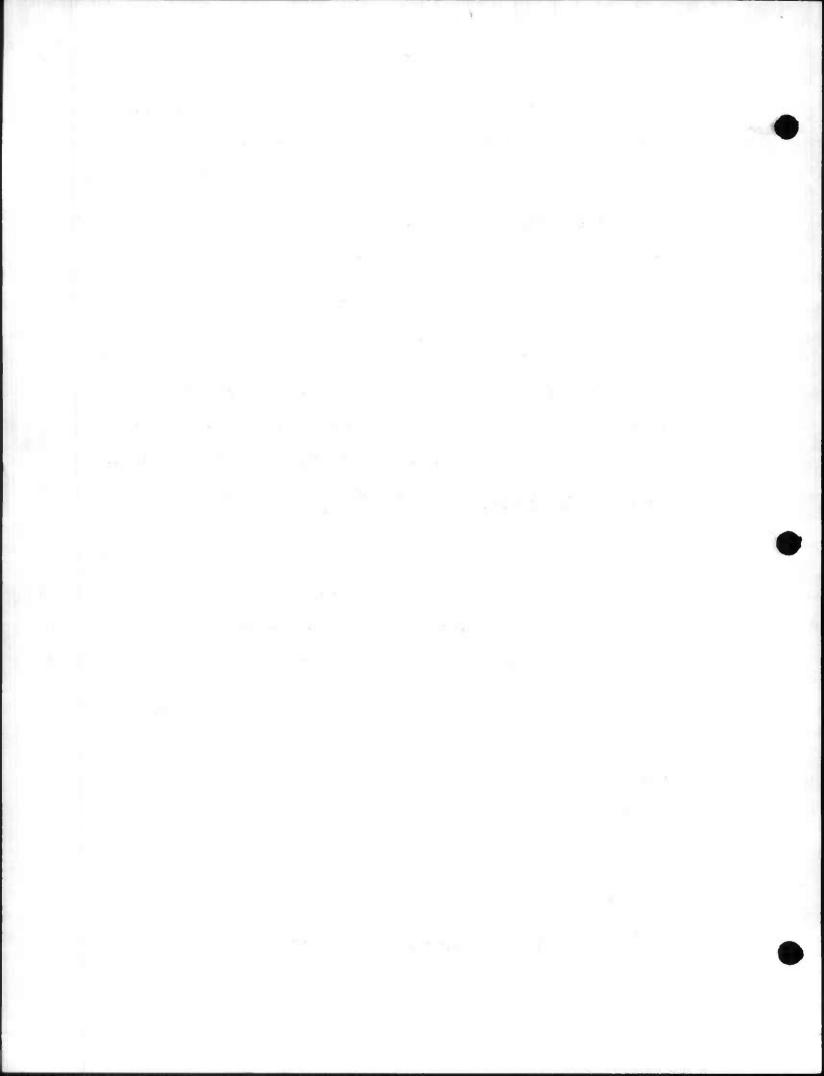
| | | 1. Decedent's Name (First, Middle, La | est) | | | | | | Reg. ate of Death | | | 3. Time of Death | |
|--|---|--|---|--|--|---|---|--|---|--|---|--|--|
| Physic: /Medi | | FAY | GA | LL | ANT | T | | | UST 22 | Day 199 | Year 7 | 6:10PM | |
| Examir | | 4e. Facility Name (If not institution, give | ve street end numbe | r) | | | 4b. City, Tov | vn, or Location | | 4c. County | | 0.10111 | |
| | | HEBREW HOME OF GR | REATER WAS | HINGT | ON | | ROCKV | ILLE | | MONTG | OMERY | | |
| Funerai | | | Sex 7. A 1 ☐ M 2 文 F | Nge (In yrs. | lest birthday) Yrs. | If Under 1 Yes Months Day | | Min. (A | ate of Birth Ionth, Dey, Ye | | | ace (Stete or Fore | |
| within 72 hours efter death v iene. than "natural", or flems 23a tra Mod cal Examing must | | 127-28-6614 Usual Residence of Decedent | | | | | | JAN | . 15, | 1904 | RUSSI | A | |
| | | 10a. State 10b. County | 10c. City, Town or Location | | | | | 10d. Inside City | | | d. Inside City Lin | | |
| | ctor | MARYLAND MONTGOME | ROCKVILLE | | | | | 1 🔀 Yes 2 € | | | 1 ₹ Yes 2 □ | | |
| | al Director | 10e. Street and Number 6105 MONTROSE ROAD | | | | 10f. Zip Code 20852 | | | | 10g. Citizen of What Country? USA | | | |
| | by Funeral | 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced | Armed Forces 1 Yes 2 V | 2. Wes Decedent Ever in U,S. Armed Forces? 1 _ Yes _ 2 NO If Yes, Give A Year or Dales: | | 13. Wes Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rice 1 ☐ Yes 2 ☑ No Specify: | | | n, etc.) Bleck, Wi | | ck, White, e | merican Indien, /hite, etc. WHITE | |
| | ted | 15. Decedent's Education (Specify only highest grede completed | | 16e. | | e. Decedent's Usual Occupation | | of warking | 16b | 16b. Kind of Business/Industry | | | |
| | Completed | Elementery/Secondary (0-12) College (1-4 | | 5+) | life. D | (Give kind of work done during most of work life. DO NOT use retired) MEMAKER | | or working | OW | OWN HOME | | | |
| | Ö | 17. Fether's Neme (First, Middle, Last, |) | | | | 18. Mother | 's Name (Firs | | | | | |
| 9 9 6 | To Be | SAMUEL SOLOMAN | | | | | | HA KALI | | | | | |
| d 2 should be thend Mente 7 is merked traumatic ex | | 19e. Informent's Name/Relationship (| Type, Print) | | 19b. Mailin | g Address (Stre | | | | ty or Town, | Stete, Zip | Code) | |
| 5 m 01 F | | MYRNA GALLANT GOL | DENBERG/D | GHTR. | 9328 | GARDEN | COURT, | POTOMA | C, MAR | YLAND | 208 | 54 | |
| of Healt | | 20a. Method of Disposition | 7D | | lece of Disposemetery, crem | sition (Neme of netory or other p | lece) | De | e 20c | Location - | City or Tov | vn, State | |
| permit. Pages Depertment of Important: If I any Injury or once. | | 1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif | | 9 | | MORIAL | | 8/24 | /97 OL | NEY. | MARYI. | AND | |
| | | 21. Signature of Funeral Service Ligar | 5060 | | 22. | Name and Add | ress of Facility | 1 | | | | | |
| | | DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 2085 | | | | | | | | | | | |
| | | 23a. Part1. Enter the disease, or com shock, or heart failure. List only | plications that cause | ad the death | Do not not | 10 HOOK | A THIR I | TILL | CONVIT | الم وبابد | | | |
| hysician /Medicai | | Immediate Cause (Final | | | | | | | | | | Approximate interval Between Onset and Death | |
| /Medicai Examiner | aminer | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, | a. CHR | Due to (o | | SCHEN uence of): | | | | | | Approximate finitional Between Onset and Death | |
| /Medical passented of business and business and business and business and business are the private and business and business are the private and business are the | n/Medical Examiner | disease or condition | | Due to (o | T s | SCHEMuence of): | | | | | | Approximate interval Between Onset and Death | |
| /Medical passented of business and business and business and business and business are the private and business and business are the private and business are the | ledical | disease or condition resulting In death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting In death) Lest | a. C H R (| Due to (or | r as a consequence as a | SCHEM uence of): uence of): | AIC (| CARI | IOMY | 10PA | THY | Onset and Death | |
| the attending physician end particular set for use as the buriel-transit | ledical | disease or condition resulting In death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events | a. C H R (| Due to (or | r as a consequence as a | SCHEM uence of): uence of): | AIC (| CARI | IOMY | 10PA | THY | Onset and Death | |
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| been signed by the attending physician and should be detached for use as the buriel-transit | by Physician/Medical | disease or condition resulting In death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting In death) Lest | a. C H R (| Due to (or | r as a consequence as a | SCHEM uence of): uence of): | AIC (| CARE | O / O M S | CO USO COI | ntribute to 3 Probe | the causa of dea | |
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| been signed by the attending physician and should be detached for use as the buriel-transit | Completed by Physician/Medical | disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Part II. Other significant conditions of the con | a. C H R (| Due to (or | r as a consequence as a | SCHEM uence of): uence of): | AIC (| CARE | 3b. Did tobac 1 Ves 4a. Was an au performed | OPA | ntribute to 3 Probi | the cause of dea ably 4 Unkn | |
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| within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician end Completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit | ledical Certification: To Be Completed by Physician/Medical | disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Lest Part II. Other significant conditions of the caminer? 1 Yes 2 No 27. Meaner of Death 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be determined. 29a. Certifier (Check only Medical Exam | a. CHRC b c d contributing to death to the series of Injuiding, expected and manners of the series of the | Due to (or Due to | r as a consequence of a | uence of): uence | 26. Plece- other: 42 Nun uny at ork? Yes 2 Ne time, date and opinion, death | of Death (Chessing Home & 28d. Color place, and dun occurred at the control of th | 3b. Did tobac 1 Yes 4a. Was an aperformed 1 Yes ck only one) Residence escribe how in ccation (Street by or Town, Si e to the cause the time, date: | Date signed | ntribute to 3 Probe 24b. Wer avair | the cause of deal ably 4 Unknown to the cause of deal ably 4 Unknown to the pletion of cause eath? Yes 2 No Route Number, Ited. Ithe cause(s) | |
| been signed by the attending physician and should be detached for use as the buriel-transit | Medical Certification: To Be Completed by Physician/Medical | disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Part II. Other significant conditions of the conditions of the caminer? 25. Was case referred to medical examiner? 1 Yes 2 No 27. Meener of Death 1 Natural 5 Pending Investigation 1 Natural 2 Accident 3 Suicide 4 Homicide 4 Homicide 4 Medical Examiner 1 Certifying Physical Processing Part 1 Certifying Physical Physical Part 1 Certifying Physica | a. CHRC b c d contributing to death of the contributing to death of the contribution of the contributio | Due to (or Due to | r as a consequence of a consequence of as a consequence of a conseque | uence of): uence | 26. Plece- other: 44 Nun uny at ork? e time, date and opinion, death | of Death (Chessing Home & 28d. Color place, and dun occurred at the control of th | 3b. Did tobac 1 Yes 4a. Was an aperformed 1 Yes ck only one) Residence escribe how in ccation (Street by or Town, Si e to the cause the time, date: | Date signed | ntribute to 3 Probe 24b. Wer avair | the cause of dealed the ca | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 27163

| | | | | | , | Cei | rtificate | e of | Death | , | Reg. No. | 1 4 | . / 1 | 00 |
|-------------|--|-------------------|---|---|--------------------------|----------------------------------|------------------------------|----------------|--|---|------------------------------------|--------------------------|--|----------------------------------|
| | DI VIV | | 1. Decedent's Neme (First, Middle, L | ast) | | | | | | 2. Deta of De Month | | Yeer | 3. Time | ot Death |
| | Physici /Medi | | TIMOTHY | L | | | HUTTO | N | | | 17.199 | | 10: | 45 p |
| | Examir | | 4a. Fecility Neme (If not institution, g | ive street end number) | | | | | 4b. City, Town, or | | | | | |
| | | | THE JOHNS HOPKIN | NS HOSPITAL | | | | | BALTIMOR | E CITY | CITY | 7 | | |
| | Funeral | г | | | | lest birthday) | if Undar | 1 Yaar | If Undar 24 Hrs | 8. Date of Birt | | 9. Birthp | leca (Stet | a or Foreign |
| | Director | | 214-02-9346 Usuel Residence of Decedent | 1 ⊠ M 2□ F | 14 | Yrs. | Months | Deys | Hours Min. | NOV. 16 | 1982 | MAR | YLAND |) |
| | show | 5 | 10e. Stete 10b. County | | 10c. Cit | y, Town or Lo | ocetion | | | | | 1 | - | City Limits |
| | Ne N | Directo | MARYLAND ANNE AR | UNDEL | PASA | ADENA | Table 2 | | | | | | | 2 2 110 |
| | with t | ក | 10e. Street end Number | | | | 10f. Zip | | | | 10g. Citizen of \ | | itry? | |
| | a 23 | era | 1076 VENA LANE | 12. Wes Decadent 8 | Secreta III | 6 40.1 | | 1122 | | >===**. V===== N== | 14 000 | US a - Americ | an Indian | |
| 0200-6 | 7.72 hours after death with the Maryland "nature!", or items 23a or 28a-f show adical Examiner man be nothed | by Funeral | 11. Marilal Status XXNever Married 2 Married 3 Widowed 4 Divorced | Armed Forces? | | | | | Hispanic Origin? (Sen, Mexican, Puer Specify: | to Rican, etc.) | Specify | ck, White, | etc. | ACK |
| 2 | 2 ho | ted | 15. Decedent's I | Education | _ | 16e. Dece | dent's Usua | Occup | petion | 4.2. | 16b. Kind of B | usiness/Ind | dustry | |
| 717 | within ene. then | Completed | (Specify only highest g Elementery/Secondary (0-12) 8th | College (1-4or 5 | +) | life. | | | during most of wo d) DENT | nking | | CCII | 201 | |
| | Hygin ther | | 17. Fathar's Neme (First, Middle, Las | | | <u> </u> | | 3101 | | me (First, Middle, | Melden Sumen | SCHO | JOL | |
| maryland | S d a S | o Be | WILLIAM BRIDGE | , | | | | | | | | .0) | | |
| ary | d 2 should Ih and Men 7 Is marked traumatic | 2 | 19e. Informent's Name/Reletionship | | | 19b. Mailir | na Address | (Street | and Number or R | L HUTTO | | Stete. Zip | Code) | |
| | ha ha 7 is | | BETTY HUTTON (MOT | _ | | | - | | IRE LANE | | | | | |
| ນົ | - 7 E E | | 20e. Method of Disposition | | 20b. P | leca of Dispo | sition (Nem | e of | T | Dale | 20c. Location | - | | |
| 2 | | | 1 Buriel 2 □ Cremetion 3 4 □ Donetion 5 □ Other (Spec | | | colls BI | - | | | 8/21/97 | ODENTON | MD | | |
| pailillore, | 구두후루 | | 21. Signature of Funeral Servica Lice | | 1120 | | | | ess of Facility | 0/21/5/ | ODLINION | , 110 | | |
| ŏ | Departiment of the sany from the sany from san | | 1-1- M | D. | | W | 1. REF | ESE | & SONS M | ORTUARY, | P.A. | | | |
| | | | 23a. Pert1. Enter the dispese, or con shock, or heart feiture. List onl | nplications thet caused | ihe deat | h. Do not ent | or the mode | T of dy | T ANNAP | OLIS MI | Prést, 21401 | | Approxim | nete |
| | Physician | | shock, or heart feiture. List onl | y one ceuse on each lin | 10. | | | | | | | | Onsal an | Between ad Death |
| | /Medicai | L | Immediate Ceuse (Finel disaese or condition | Peso | 20 | TORY | Fau | . 12 | 6. | | | | / WEE | |
| | Examiner | | resulting in death) | 0 | | r es e consec | | | | | | | 1-66 | |
| - | D # | ne. | _ | END. | 5746 | e Lune | & Dis | ¢ 0.5 | E | | | 1 | 8 161 | 17215 |
| | and -trans | Examiner | Sequentially list conditions, | 0. | Due to (o | r es e consec | quence of): | | | | | | | |
| Ç, | death certificata be assecuted e ettending physician and of for use as the bunel-transit | | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury | STATUS | 805 | T B | LATE | RA | LUNG | TRANSIL | AVT | | 13 M | PHITHS |
| 00/00 | cata physi the | Physician/Medical | thet initieted events resulting in deeth) Lest | | | r es e conseq | | | | | | 1 | | |
| X | certific ding p | /Me | | d. 10109 | ATH | IC PL | ILMOR | MG: | T FIBROS | (.5 | | į | 10 YE | ARS |
| 200 | eath cer ettendin I for use | ciar | | | | | | | | | | | | |
|) | y the d | ysi | Pert II. Other algnificant conditions | contributing to death bu | it not resi | ulting In the u | nderlying ca | use gi | ven in Pert i. | | obacco usa co | | | |
| Ļ | that ned b | by Pt | | | | | | | | 1 🗆 | Yes 2 No | 3 □ Proi | bably 4 | Unknown |
| ecolos, | law requiras that the de as been signed by the of 2 should be detached | Completed b | | | _ | | | | | 24e. Wes | en eutopsy med? | ev | ere autops aliable prid mpletion o death? | sy findings or to of cause |
| | 0 4 5 | EO | | | | | | | | 10 | res 2 No | 10 | Yes 2 | No No |
| AIIA | ician: The certificate rector, pag | Bec | 25. Was casa referred to medical | | | | _ | | 26. Piece of De | eth (Check only o | ne) | | | |
| > | yslcl is ce direc | To | examiner? 1 ☐ Yes 2 No | Hospital: Inpatie | nt 2 🗆 | ER/Outpatier | nt 3□ DO | A Oti | her: 4 Nursing I | toma 5□ Rasid | danca 6 Oth | er (Specif | y) | |
| 5 | g Ph | | 27. Menner of Deeth | 28e. Dete of Injur (Month, Dey | | 28b. Time of Injury | | Bc. Inju Wo | | _ | now injury occur | | | |
| NISIOII A | auth. or: Af | atlo | 1 Naturel 5 Pending 2 Accident investigation | on | , , , | ,, | М | | Yes 2□No | | | | | |
| | aftar de Directo | Certification: | 3 Suicide 6 Could not determined | | ry - At ho . (Specif) | ome, ferm, str | eet, fectory, | offica | | 28f. Location (S City or Tox | Street end Numb vn, Stete) | per or Aura | il Routa N | umber, |
| | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completaly filled in by the funeral director, | edical C | 29a. Certifier (Check only one) Certifying P | hysician: To the best o miner: On the basis of end menner ste | examine | wledge, deeth tion end/or Inv | n occurred e vestigetion, | t the ti | me, dete end plece opinion, deeth occ | e, end due to the urred at the time, | ceuse(s) end mo dete and plece, | enner as s and due to | tated. the caus | 0(3) |
| | vithin outh | Me | 29b. Signeture end title of certifier | | | | 29c. | Licens | se number | | 29d. Dete signe | d (Month, | Dey, Year |) |
| | - s + ō | | 1000 | (| - | MD | 1 | ZES | -000 | | AUGUS- | | | |
| | | | 30. Neme end eddress of person who | completed cause of de | eth (Item | 23e) /Tune | Print | | | | | • | | _ |
| | | | CHRUS SOMME | | | | | 381 | rac Ton | £2110 | | | | |
| | Sta | te | 31. Dete filed (Month, Day, Yeer) | 32. Registre | r's Signe | ture | | | | | | | | |
| | Pogistr | | ALIC 91 | | | · 1 % | | | | | | | | |



| | | Decedant's Nam | a /First Middle I | | f Maryla | nd / Depa <i>Cer</i> | irtmen tificat | it of F e of i | lealth a Death | , | | giene 9 Reg. No. | 7 2 | 271 | 1.12 |
|--|------------------|--|-------------------------------------|---|---------------------------------|---|---|-------------------------|--------------------------------|-----------------------|---------------------------------------|------------------------------------|------------------------------|--|------------------|
| Phys /Me | ician dical | | a (1 1131, MIDDIA, L | Haber | | | | | | | 2. Data of Da Month Augus | Day 14, 19 | Yeer 97 | 1000 | of Death 8 AM |
| Exar | niner | 4a. Facility Nama (/ | | iva street and nui neral Ho | | | | 4 | olney | 7 | ation of Daat | | | | |
| o Funer Directe | _ | 5. Social Security N 060-03-24 | umber 6. | Sax 1□M 2ŒF | | last birthday) Yrs. | If Under Months | 1 Year Days | If Undar 24 Hours | 4 Hrs. Min. | 8. Date of Bir (Month, Da larch | | 9. Birthp Coun Engl | ece (State | a or Foreign |
| r 28a-f show | ò | Usual Rasidance of 10a. State FL | 10b. County Broward | | | ity, Town or Loc | | lead | | | | | 11 | | City Limits |
| th with the A 23a or 28a- | Funeral Director | 10e. Street and Nur 2951 N.W | nber | venue. A | | | 10f. Zip | | 3 | | | 10g. Citizan of United | | try? | |
| ter dea | by Funera | 11. Marital Status 1 □ Nevar Marri 3 ፟ Widowad | ed 2 Married | | edant Evar in Urcas? 2 12 No | J,S. 13. V | | dant of H | | in? (Spec Puarto R | cify Yas or No lican, atc.) | 14. Rad Bia | ce - America ck, Whita, e | an Indian, etc. | |
| 2121 I within iene. I than " | ompleted | (Spec | 15. Decedant's 8 ify only highast g | | -4or 5+) | | ant's Usua kind of wor OO NOT us okkee | rk dona d sa ratired | ation fu <i>ring</i> most o | of workin | g | 16b. Kind of B | | ustry | |
| yland 212 buld be filed withi Mental Hygiene. arked other than attic event, the M | To Be C | 17. Fathar's Nama (| | st) | | , B0 | Oleheet | · | | | (First, Middle, | Maldan Suman | - 4 | | |
| Baltimore, Maryland ; permit. Peges 1 and 2 should be filed Depertment of Health and Mental Hyp Important; If Item 27 is marked other any injury or other traumatic event, | | | aron - No | ephew | | | Cuts ition (Nam alory or o | stone | e Way, | Sil | | oring, M 20c. Location N. L | D 20 City or To | 905 wn, Stata | , FL |
| Ball Permit. Dependingon | Buce | 21. Signatura of Fu | naral Servica Lice | D. W. | nol | 22. | Nama an | d Addras | s of Facility | Star | of Da Laude | vid Mem | orial FL 3 | Cha ₁ 3068 | pel |
| Physician /Medica Examine | il r | Immediata Causa (disaasa or conditior rasulting in daath) | Final | a. My | ach lina. | | | | g, such es ca | ardiac or | raspiratory a | rrest, | 1 | Approximation Interval Brown on Sat and | atween |
| 58 760, icete be executed physician and s the bunal-transit | Examiner | Sequantially list cor if any, laading to Im cause. Entar Undaa Causa (Disaasa or I that Initiated evants | editions, madiate | b. ———— | Dua to (| or as a consaqu | ance of): | | | | | | | | |
| Box 68760, leath certificate be extending physician affor use es the burial- | n/Medical | causa (Disaasa or that Initiated evants rasulting in daath) L | njury ast | d | Dua to (c | or as e consequ | anca of): | | | | | | | | |
| of by the detached | by Physician/M | Part II. Other algorithm | | contributing to de | ath but not ras | sulting In the un | dariying ca | ausa give | n In Part I. | | | obacco uae co | | | |
| Hecords, se lew requires th shes been signe ge 2 should be o | Completed b | | | | | | | | | | 24a. Was perfo | an autopsy med? | eva | ra autopsy llable prior aplation of aath? | rto |
| = = = = = | Be Co | 25. Was casa refarm | ed to medical | | | | | | 26 Piace of | t Death | 1 🗆 Y | | 10 | Yas 2 | □ No |
| ing Physical distribution | 10 | axaminar? 1 Yas 2 | | 28a. Data o (Monti | | ER/Outpatient 28b. Time of Injury | | Bc. Injury Work | ir: 4□ Nursi | Ing Home | e 5□ Rasio | lanca 6 Oth | | | |
| DIVISION Ital or Attending Irs after death. Fill Director: After | Certification: | 2 ☐ Accidant 3 ☐ Sulcida 4 ☐ Homicida | 6 Could not be datarmined | 28a. Place | of Injury - At h | oma, farm, strac y) | | | 20110 | | of. Location (5 City or Tow | Street and Numb n, Stata) | er or Rural | Routa Nui | m <i>ber</i> , |
| To the Hospital o within 24 hours af To the Funeral Di completely filled in | edicai | 29a. Cartifiar (Check only one) | T⊠ Certifying Pt 2 Medical Exa | nyelclan: To tha t miner: On the ba- and mann | sis of axamina | wledga, daath o tion and/or Inve | occurred a estigation, | it tha tim in my op | a, data and p inion, daath | piaca, an occurred | d dua to tha d at the time, | cause(s) and ma data and placa, | nnar as sta and dua to | ted. tha causa | (s) |
| To the To the comple | × | 29b. Signatura and t | | | 4 - | | 29c. | Licansa | number | | | 29d. Date signad | | | |
| | | 30. Name and addre | ss of person who | complated causs | of death (Itan |) . n 23a) (Tvpa. P | rint) A | 2774 | 126 n Sui | رر کان | 6060 | Hugust | 14,1 | 957 | |
| | | , , 0 | 111 0 24. | Ne 641 | 10 BV | . 0 | utz | , , | 30 20 | 083 | 2 | | | | |
| S Regis | tate trar | 31. Data filed (Month | i, Day, Year) | | gistrar's Signa | | LE | | | | | | | | |

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Mildred August 7:00 A.M. 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Allegis of Kensington - Mariner Health Care Kensington Montgomery County If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) 1□M 20F 84 January 4, 1913 West Virginia 10c. City, Town or Location 10d. tnside City Limits Montgomery Kensington 1 ☐ Yes 2 No 10f. Zip Code 10g. Citizen of Whet Country? 3000 McComas Avenue United States 20895 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Yes 2 No
If Yes, Give
Year or Detes: 1 Never Married 2 Married 1 Yes 2 XNo Specify: Specify: White 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Clerk Retail 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Lenora Perry gs

Herns 23a or permit. Pages 1 and 2 should be filed within 72 hours effer a Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural" any injury or other traumetic exercises.

the Maryland

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

by

Completed

5. Sociel Security Number

234-36-0634

10e. Street end Number

10a Stete

MD

Usual Residence of Decedent

3 ☐ Widowed 4 K Divorced

Elementery/Secondary (0-12)

Rumsey Grogg

12

10b. County

Physician /Medical Examiner

ed by the el deteched for

Hospital or Attending Physician: The lew requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760.

| 19e. Informent's Neme/Reletionship (T) | | 19b. Meiling Addres | ss (Street and Number or I | Pural Route Number, City or Town, | Stete, Zip Code) |
|---|---|---|---|---|--|
| Gloria Sadler/ Da | ughter | P.O. Box | 208, Fisher | town, Pennsylvan | ia 15539 |
| 20a. Method of Disposition 1 \(\bar{\Delta} \) Burial 2 \(\subseteq \text{cremetion} \) 3 \(\subseteq \) 4 \(\subseteq \text{Donetion} \) 5 \(\subseteq \text{Other} \) (Specify) | Removel from State T.1 | Plece of Disposition (M cemetery, cremetory or ttle Creek esbyterian | other place) | | Clty or Jown, Stete Sulphur Sprin t Virginia |
| 21. Signeral Service Licens | | 22. Neme of Shanl | and Address of Fecility Clin Funeral | | |
| 23a. Pert1. Enter the disease, or compi shock, or heert failure. List only o | licetions thet caused the deet ne ceuse on each line. | h. Do not enter the mo | de of dying, such es cardi | ec or respiretory errest, | Approximete Intervel Between Onset end Deeth |
| diseese or condition resulting in deeth) | в | VI | 05 8/115 | | 1004 |
| | Due to (c | or es e consequence of the lime, | s's Pireare | | Years |
| Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury | Due to (d | or es e consequence of |): | | |
| thet initieted events resulting In deeth) Lest | Due fo (o | r es e consequence of) | : | | |
| | d | | | | |
| Pert II. Other significent conditions cor | atributing to death but not ree | ulting In the underlying | anuan airren In Part I | 22h Did tohacco uso and | ntribute to the cause of death? |
| Total Significant Conditions con | minuming to deam out not res | uning in the underlying | ceuse given in Feit I. | 1 Yes 2 No | 3 Probably 4 Unknown |
| | 3 | | | 24e. Wes en eutopsy performed? | 24b. Were eutopsy findings evalleble prior fo completion of cause of death? |
| | | | | 1 ☐ Yes 2 ☐ No | 1 ☐ Yes 2 ☐ No |
| 25. Wes case referred to medical exeminer? | | | | eeth (Check only one) | |
| 1□ Yes 2□ No | fospital: 1 ☐ Inpatient 2 ☐ | ER/Outpetient 3 D | OA Other: 4 Nursing | Home 5 ☐ Residence 8 ☐ Oth | er (Specify) |
| 27. Menner of Deeth 1 Naturel 5 Pending 2 Accident investigation | 28e. Dete of Injury (Month, Dey Year) | 28b. Time of Injury | 28c. Injury et Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how injury occurr | red |
| 3 Sulcide 6 Could not be 4 Homicide determined | 28e. Plece of Injury - At he building, etc. (Specification) | ome, ferm, street, facto | y, offica | 28f. Location (Street end Numb City or Town, State) | er or Rural Route Number, |
| (Check only 2 Medical Examin | sician: To the best of my kno ner: On the basis of examine end manner steted. | wledge, deeth occurred tion end/or Investigetion | l ef the time, dete end plec n, in my opinion, deeth occ | ce, end due to the ceuse(s) end me curred et the time, dete end plece, o | onner es steted. and due to the ceuse(s) |
| one) | | | | | |
| 29b. Signeture end title of certifier |) | 29 | c. License number | 29d. Dete signed | d (Month, Dey, Year) |

State Registrar 31. Date filed (Month, Day, Year)

AUG 21 1997

11120 New Hampshire Avenue, Silver Spring, Maryland 20904 Michael Leibowitz, M.D. 32. Registrer's Signeture

To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral or

State of Maryland / Department of Health and Mental Hygiene Q 7

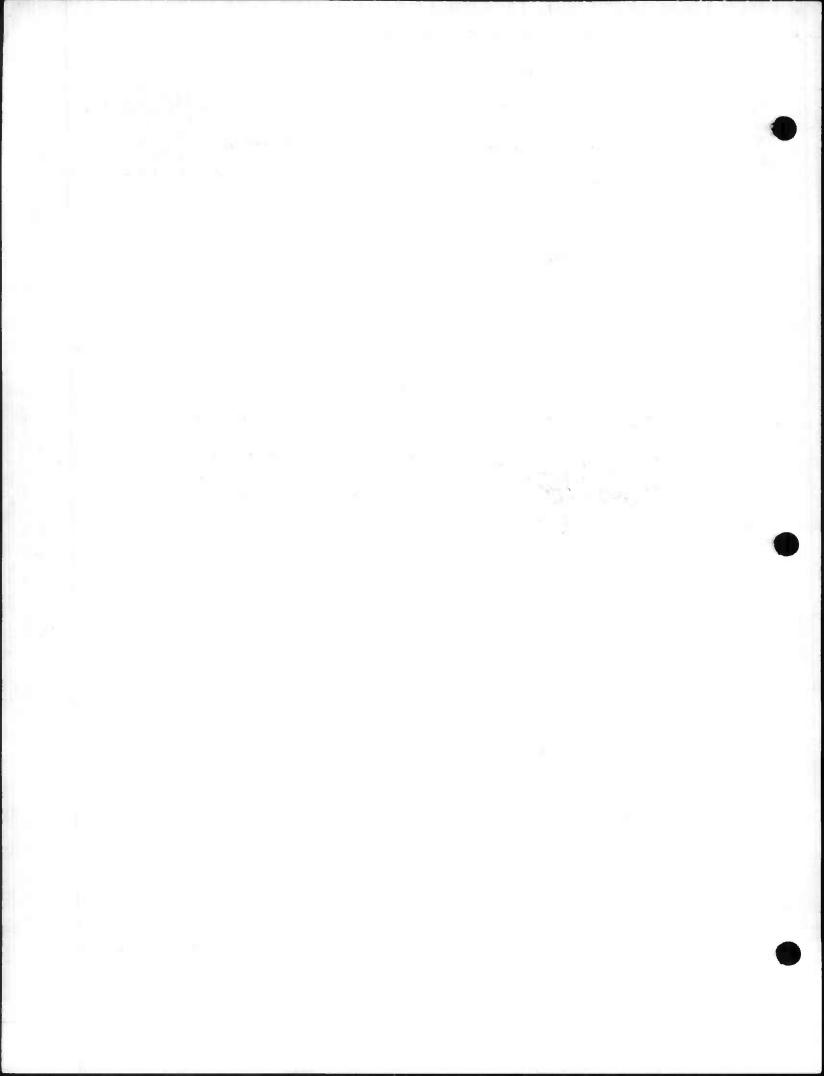
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Heinemann, SR. Month **Physician** Wickham August James 2:43 m 1997 /Medicai 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** THE JOHNS HOPKINS HOSPITAL CITY BALTIMORE CITY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 1 ☑ M 2 ☐ F 8. Date of Birth 9. Birthplace (State or Foreign (Month, Dey, Yeer) 9. Birthplace (State or Foreign Country)

JULY 6, 1942WASHINGTON DC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Yrs. 55 Director 410-66-4180 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other trsumstic event, the Modical Examiner must be notified at MD. CARROLL WESTMINSTER 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 723 JOHAHN DR. 21158 USA. death Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) pemit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or Iter any injury or other trsumetic event, the Moutan Examina-1 ☐ Never Merried 2 Merried Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ZNo Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) INVESTIGATOR TRANSPORTATION 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) CHARLES B. HEINEMANN MARY WICKHAM 19e. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALMEDA JANE HEINEMANN-WIFE 723 JOHAHN DR., WESTMINSTER, MD. 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burlat 25 ☐ Cremation 3 ☐ Removel from State CARROLL CREMATION 8/27/97 HAMPSTEAD, MD. 4 Donation 5. Other (Specify) 22. Name and Address of Facility FLETCHER FUNERAL HOME 21. Sign 254 E. MAIN ST., WESTMINSTER, MD. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medicai Immediate Cause (Finel acidemia disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner morkalemia sician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last physician s the burial P.O. Box 68760 Physician/Medical 4months Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 40 3 Probably 4 Unknown arrhosis, sportmeons Records, þ 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? diasetes meltitus 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) examiner r 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? 1 X Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es steted.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 23, 1997 RES-000 Rou Chattern 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) N. Wolfe Street, Tower 110 Baltimore, MD Rance chatteriel 601 31. Date tiled (Month, Day, Year) 22. Registrar's Signature State AUG 2 5 1997 Registrar

DHMH 16 Ray 6/95



| | | | | | State of | Maryland | d / Depa <i>Cei</i> | artment of F rtificate of | lealth and I <i>Death</i> | | giene 9 * | 7 2 | 7167 |
|---------------------|--|----------------------------|--|---------------------------------|--|---------------------------------|--------------------------------|--|--|--|-----------------------------------|-----------------------------|--|
| | Physic | ian | Decedent's Name (First Dora | t, Middia, Lasi May |) Hendi | ri okc | | | | 2. Data of Dea Month August | ith Day, | Year | 3. Time of Death |
| | /Medi Exami | | 4a. Facility Name (If not in | | | | | | tb. City, Town, or I | | 4c. County | | 6:09 A.M. |
| | Lxaiiiii | 161 | Fallston G | | | | | | Fallsto | | | larfor | rd |
| | Funeral | Г | 5. Social Security Number | 6. Se | | . Age (In yrs. ii | | If Undar 1 Year Months Days | If Undar 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day Oct. 19 | Year) | 9. Birthple | ace (State or Foreign |
| 8 | Director | | 178-20-662 Usual Residence of Deced | .5 | JM ZON | 90 | Yrs. | | | Oct. 19 | , 1906 | Penns | ýlvania |
| | /land | | | County | | 10c. City | , Town or Lo | cation | | | | 10 | d. Inside City Limits |
| | Mar Med st | ctor | Maryland | Harfor | d | Ab | erdeer | n | | | | | 1 TYes 2 □ No |
| | में 20 के | Director | 10e. Street and Number | | | | | 10f. Zlp Code | | | 10g. Citizen of \ | | ry? |
| | a 23a | | 704 Wal | ker St | | ant Francis III (| 10.1 | 21001 | | | U.S. | | n la dia a |
| Maryland 21215-0020 | s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinations in Item notified at | by Funeral | 11. Marital Status 1 Never Married 2 305Widowed 4 Di | | 12. Was Deceded Armed Force 1 Test 2 If Yes, Give Year or Dete | as? X⊠No | | Nas Decedent of H f Yes, specify Cubi I □ Yes 2000No | Specify: | pecity tas of No- o Rican, etc.) | | e - Amarica ck, White, e | itc. |
| 5-0 | 72 ho | ted | | ecedent'a Edu highest grad | | İ | 16a. Deced | ient's Usual Occup | ation | kina | 16b. Kind of Bi | usinass/Ind | ustry |
| | | Completed | Elemantary/Secondary | | College (1-4 | lor 5+) | | kind of work done | 1) | na sy | In hom | | |
| d 2 | be filed within tal Hygiene. d other than a event, tre Mer | | 17. Father's Name (First, I | Middle, Last) | 0 | | HOIR | emaker | 18. Mother's Nan | ne (First, Middle, | | | |
| an | id be ental ked o | To Be | George | | ahev | | | | | e Lindem | | , | |
| ary | and Men a marke | - | 19a. Informant's Name/Re | | | | 19b. Mailin | ng Address (Street | | | | State, Zip | Code) |
| ∑ : | and 2 ealth a n 27 is her trau | | Mr. George | | dricks | | | Pleasantv | ind Driv | e, Aberd | leen, Ma | rylar | nd 21001 |
| aitimore, | Page nent o ant: If | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cren 4 ☐ Donation 5 ☐ O | nation 3 🗆 F | | ate C6 | metery, cren | sition (Nama of natory or other place Memorial | | | 20c. Location - Bel Air | | |
| Bait | permit. Departr Imports any inje | | 21. Signature of Funeral S | Sarvice Licens | ee R | | 722 To | Name and Address arring-Caberdeen, | ss of Facility 1790 Fune | ral Home | , P.A. | | |
| | Physician /Medicai Examiner | | 23a. Part1. Enter the dise shock, or heart failur Immediete Cause (Final dlaaasa or condition resulting In daath) | a. List only o | a Core | gro u | | ulen | | | | | Approximate Interval Between Onset and Death |
| Box 68760, | that the death certificate be executed ed by the attending physician and detached for use as the burial-transit | Physician/Medical Examiner | Sequentially list condition if any, leading to immedia cause. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last | s, te | o | | as a consequal as a consequal | | | | | | |
| 0. | the att | ysici | Part II. Other significant c | onditions cor | ntributing to deat | h but not resul | Iting in the ur | nderlying causa giv | an In Part I. | 23b. Did to | obacco use co | ntribute to | the cause of death? |
| s, P.O | as that the igned by be detact | by Ph | am | nary | art | ly | de | reese | | 1 🗆 Y | res 2□No | 3 Prob | ably 40 Unknown |
| Records, | aw requir as been s 2 should | Completed | | | | (| | | | 24a. Was a perfor | an autopsy med? | ava | re autopsy findings ilable prior to apletion of cause eath? |
| | | Соп | | | | | | | | 1 🗆 Y | as Dano | 10 | Yes 2000 |
| Vital | certificata rector, pag | Be | 25. Was case referred to reexaminer? | | lospital: | | - | 011 | A 4 | th (Check only or | | | 7 |
| ō | 5 5 | : To | 1 ☐ Yas → No 27. Manner of Death | | 1 L Inp | | R/Outpatien 28b. Time of | | 41 Wursing H | oma 5 Resid | | | |
| lo . | th. : After | ation | 1 Datural 5 | Pending Invastigation | 28a. Date of (Month, | Day Year) | Injury | 28c. Injur Wor M 1 □ | k? Yas 2□No | 200. 0000110011 | ow injury occur | 160 | |
| | | Certification: | 3 ☐ Suicide 6 ☐ | Could not be determined | 28e. Place of building | Injury - At hor, atc. (Specify) | me, farm, stre | eet, factory, office | | 28f. Location (S City or Tow | treet and Numb n, State) | er or Rural | Route Number, |
| | To the Hospital or within 24 hours after To the Funeral Dir completaly filled in | edical (| 29a. Certifier (Check only one) | ertifying Phys edical Examin | alcian: To the besi | s of examination | riedge, death on and/or inv | occurred at the tir rastigation, in my o | ne, date and place plnion, death occu | , and due to the c rred at the tima, d | ausa(s) and ma late and place, | anner as sta | ited. the cause(s) |
| | To the company | X | 29b. Signature and title of | oert lier | RC | | | 29c. Licens | number 33g | | 29d. Data signe | d (Month, D | lay, Year) |
| | 20 | | 30. Name and address of p | person who co | emplated cause | of death (Item | 23a) (Type, I | Print) Air M | D ar | 115 | ye! | 1-14 | |
| | Sta Registr | | 31. Date filed (Month, Day, AUG 2 | 7 1997 | 32r Reg | istrar's Signati | Rardal | 6, | in. Ok | | | | |

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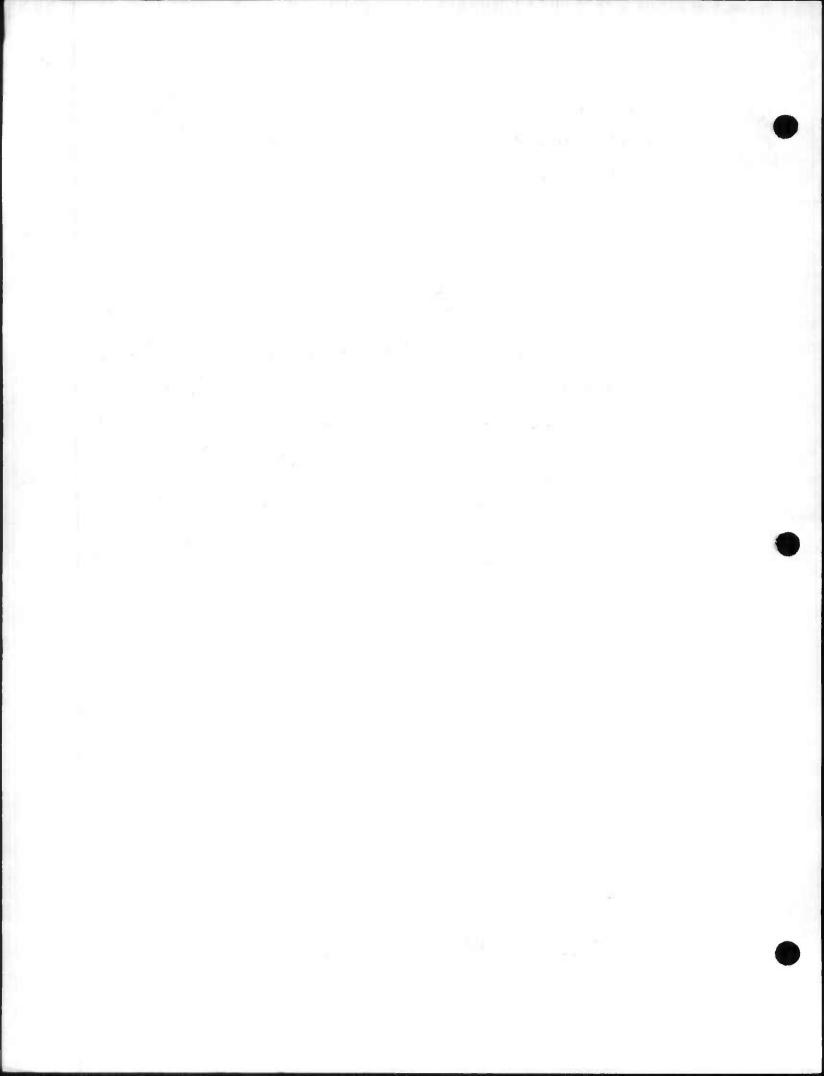
State of Maryland / Department of Health and Mental Hygiene 97 27 | 68

| | | | | | | | Ce | rtificat | e of | Death | | F | Reg. No. | | |
|------------|--|---------------|--|------------------------------------|---------------------------|-----------------------------|------------------------|----------------------------|-------------------------|-----------------------------|-----------------------|---|--------------------|-------------|--|
| | Physic | ian | 1. Decedent's Name | - | earl | Fred | Hav | enga | | | | 2. Date of Dea Month | ith Day | Year | 3. Time of Death |
| | /Medi | cai | An English Name (III | | | | IIav | enga | | th Oh. To | | August | | | 4:30 PM |
| | Exami | ner | 4a. Fscility Name (If n | Davis | | umber) | | | | | | Grace | | Harf | |
| _ | | | 5. Social Security Nur | | Sex | 7. Aga (In yrs. | last hirthday | If Undar | | | | | | | |
| | Funeral Director | | 366-12-8 Usual Residence of D | 282 | 1 X M 2□ F | Triga (irryio | 77 Yrs. | Months | Days | Hours | Min. | 8. Data of Birth (Month, Day 09-22- | 1919 | Cou | nplaca (Stata or Foreign untry) MI |
| | yland | | 10a. Stata | 10b. County | | 10c. C | ity, Town or L | ocetion | | | | | | | 10d. inside City Limits |
| | Mar | to | MD | Har | ford | | | | Hav | re de | Gr | ace | | | t ☐ Yas 2 No |
| | or 28 | Director | 10e. Street and Numb | per | | | | 10f. Zlp | Coda | | | 1 | log. Citizen of | What Cou | intry? |
| | 23a | la | 100 | 5 Davis | Drive | | | | 2 | 21078 | | | | USA | 4 |
| | term to me | Funeral | 11. Maritai Status | | Armed F | | J,S. 13. | Was Deced | lant of I- cify Cubi | lispanic Ori an, Maxicar | gin? (Sp i, Puerto | ecify Yas or No- Rican, etc.) | | ce - Amar | ican Indian, |
| 21215-0020 | filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Nerma 23s or 28s-f show ont, the Med cell Exeminer must be notified at | by | 1 Nevar Married 3 Widowed 4 | | W Man C | 2 No live Datas:1943- | | 1□ Yes | | | | | Specif | v. | Vhite |
| 15- | natu | Completed | (Specify | 5. Decedent's E only highest gr | ducetion ada completed |) | (Give | dent's Usua kind of wor | rk done | durina mos | t of work | ing | 16b. Kind of B | usiness/li | ndustry |
| 12 | withir she. | dmo | Elementary/Second | dary (0-12) | College | (1-4or 5+) | | ld Re | | , | ivo | | Autom | otive | Company |
| d 2 | be filed withintal Hygiene. d other than | | 17. Father's Name (Fi | irst, Middle, Las | 1) | | 1 16 | iu ite | pres | | | a (First, Middla, | | | Company |
| Maryland | S E D S | To Be | | | Haven | ga | | | | | | Ima Ricl | | , | |
| ary | d 2 should th and Mer 7 is marks traumatic | - | 19a. Informant's Nam | | | <i></i> | 19b. Malli | ing Address | (Street | and Numbe | | al Route Numbe | | State, Zi | ip Code) |
| | nd 2 sulth ar 27 la r trau | | Mrs. Rutl | h Haver | nga - W | life | | | | | | vre de | | | |
| re, | s 1 a of Hac litem ofthe | | 20a. Method of Dispos | sition | | 20b. | Place of Disp | osition (Nan | ne of | nel | | Date | 20c. Location | - City or T | own, Ststa |
| E | Peges 1 and 2 nent of Haelth e ant: if Item 27 le ury or other tra | | 1 ☐ Burial 2 🗵 4 ☐ Donstion 5 | | | State | | | | * | nc 8 | /26/97 | West C | Chest | ter. PA |
| Baltimore, | permit. Peges 1 and Department of Health Important: if Item 27 any Injury or other to | | 21. Signatura of Funs | aral Service Lice | nsep | 2 | | Name an Mitch | d Addre | ss of Facilit | , Fu | neral H | ome, P | .A. | |
| | _ | | 23a. Part 1. Enter the | disaase, or com | plications that | ceused the dans | th. Do not en | | | | | MD 21 | | 97 | Approximate |
| × | Physician | | shock, or heart (| fallure. List only | one cause on | each line. | | | | | | | | | Approximate Interval Between Onset and Death |
| и | /Medical | | Immediate Causa (Findisaasa or condition | nal | ME | TAST | mc | AD | NE1 | NOCA | 720 | CINOV | nA | į | 6 MONTHS |
| П | Examiner | | resulting in death) | | a | | or as a conse | | • | | | | | | |
| | D 45 | iner | | _ | | | | | | | | | | | |
| ó | that the death certificate be associted ed by the attending physician and detached for use as the bunal-transit | Examiner | Sequentially list cond if any, leading to imm cause. Enter Undarly Causa (Disaase or Inj | litions, rediate ring | D | Due to (| or as a conse | quence of): | | | | | | | |
| 68760, | ificate be g physici as the bu | Medical | that initiated events rasulting in death) La | | c | Due to (d | or as a consec | quence of): | | | | | | | |
| Box | eath certific attending pl | | | | d | | | | | | | | | | |
| | deati | Physician/ | Part II. Other significa | ant conditions of | contributing to a | seath but not ras | sutting in the u | ınderivina cı | eusa giv | en in Part i | | 23b. Did to | obacco use co | ntribute | to the cause of death? |
| P.0 | that the dended by the a | Å. | | | | | | | | | | | | 3 □ Pro | ./ |
| | 8 5 8 | by | | | | | | | | | | | | | |
| Records, | s been s | Completed | | | | | | | | | | 24s. Was a perfor | in sutopsy med? | a | Vera autopsy findings vsilable prior to ompletion of cause f death? |
| Ä | g - 5 | E O | | | | | | | | | | 1 U Y | as 20 No | 1 | □Yas 2□ No |
| ita | ysician: The s certificate director, pag | Be | 25. Was cese refarred examinar? | d to medical | | | | | | 28. Piaca | of Deat | h (Check only or | ne) | | |
| of Vital | ig i | 인 | 1 ☐ Yes 20 No | 0 | Hospital: 1 🗆 | Inpatient 2 | ER/Outpatle | nt 3 DO | A Oth | er: 4 🗆 Nu | ırsing Ho | me Reside | ence 6 Oth | ar (Spec | ify) |
| | | Certification | 7 | 5 Pending | | of injury oth, Day Year) | 28b. Tims of Injury | if 2 | 8c. Injur Wor | yat k? Yes 2 □ | İ | 28d. Describe h | ow injury occur | red | |
| Division | Attending ir death. octor: After by the fune | fice | | 6 Could not be | e oge Stee | e of injury - At h | ome, farm, st | | | | | 28f. Location (S | treet and Numi | ber or Rui | ral Routa Number, |
| S | after Dire | ert | 4 Homicide | Mare I I I I I I I | | ling, etc. (Speci | (y) | | | | | City or Town | n, Stste) | | |
| | To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by | | 29a, Certifier | Certifying Ph | yelcisn: To the | e best of my kno | wledge, deat | h occurred a | at the tir | ne, date sn | d place, | and due to the c | ause(s) and m | snner ss | stated. |
| | M Ho | edical | Check only 2 | Medical Exar | niner: On the b | pasis of axamina | ition and/or In | vestigation, | in my o | pinion, des | th occurr | red st the time, d | ate and place, | and dua | lo tha cause(s) |
| | To the To the Comp | ≥(| 29b. Signature and titl | te of contiller | 1 | X | NAK | 290 | Licens | a number | P | | 9d. Data signe | d (Month | , Day, Year) |
| | ✓ | | MA | 1 7 | ilw | | Sur) | | D | 31 | 77 | | Augus | st 26 | , 1997 |
| | 10 | | 30. Name and address | s ot person who | complated cau | sa of death (Itar | n 23a) (Type, | Print) | 0 | <u> </u> | | | | | |
| | , | | | | ds, M. | D., 211 | 2 Bel | Air R | load | , Fal | Istor | n, MD 2 | 1047 | | |
| | Sta | | 31. Date filed (Month, | | 97 324 | Agristral 4 Sign | Mark Mark | D. | | | | | | | |
| | Registr | ar | AU | G 2 6 19 | 10 | | | | | ٠ | | | | | |

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State of Maryland / Department of Health and Mental Hygiene 97 27 169

| | | | | | | Cer | tificate of | f Death | | Reg. No. | | ton I | |
|------------|--|----------------|---|---|------------------------|------------------------|--------------------------------------|---|---|---------------------------|---------------------------------|-------------------------|---------------------------------|
| | - | . 1 | 1. Decedent's Name (First, Middle, La | st) | | | | | 2. Date of D | eath | | 3. T | ime of Death |
| | Physic /Medi | | Victor Atwoo | d Howard | | | | | August | 26, | 1997 | 12 | :35PM |
| | Exami | | 4e. Fecility Name (If not Institution, giv | e street end number) |) | | | 4b. City, Town, o | or Location of Dea | | County of Dee | th | |
| Ĺ | | | Rockville Nursi | ing Home | | | | Rockv | ille | 1 | lontgom | ery | |
| | Funeral Director | | | ex ☐ M 2☐ F | ge (In yrs. last b | irthday) Yrs. | If Under 1 Year Months Dey | | n. (Month, D | rth ay, Year) 25, | 9. Bir CC 1907 V | thplace (Sountry) ermo: | Stete or Foreign |
| | 72 hours efter death with the Meryland netural; or items 23e or 28s-4 show dical Examiner must be notified at | tor | Usuel Residence of Decedent 10a. State 10b. County Maryland Montgome | rv | 10c. City, Tow | | | | | | | | side City Limits XYes 2 □ No |
| | r 28a | Director | 10e. Street end Number | Ly | ROCKV | 1116 | 10f. Zlp Code | | | 10g. Citiz | zen of What Co | ountry? | |
| | 30 o | | 643 Azalea Drive | | | | 2085 | 0 | | Unit | ed Sta | tae | |
| | death | Funeral | 11. Marital Status | 12. Was Decedent | | 13. W | Vas Decedent of | Hispenic Origin? | (Specify Yes or N | | 14. Race - Ame | | lien, |
| 040 | thin 72 hours efter death with the Merylan an "netural", or items 23e or 28s-f show Medical Examiner mant be notified at | by Fur | 1 Never Married 2 Married 3 Widowed 4 Divorced | Armed Forces? 1 X Yes 2 If Yes, Give Yeer or Dates: | , № World War II | 1 | Yes, specify Cu | o Specify: | erto Rican, etc.) | | Bleck, Whit Specify: | ite, etc. | |
| 5 | 2 ho | | 15. Decedent's Ed | ducation | | . Deced | ent's Usuai Occ | upation | | 16b. Kir | nd of Buainess | | |
| 200-61212 | within ene. then | Completed | (Specify only highest green Elementary/Secondary (0-12) | de completed) College (1-4or : | 5+) | (Give I | kind of work don OO NOT use retir | e during most of w red) fety Off | | | trict Govern | of Co | olumbia |
| 2 | 長去草草 | BeC | 17. Father's Name (First, Middle, Last) | | - | CIOO | mici ba | | ame (First, Middle | , Maiden | | ment_ | |
| 0 | 0 5 0 e | To B | Henry Clement How | ard | | | | Charlo | tte Mary | Atric | hod | | |
| 31 3 | 4 DEE | - | 19a. Informent's Neme/Relationship (| | 19 | b. Mailine | a Address (Stree | et end Number or | | | | Zip Code |) |
| Mai ylalla | C/ 0 = 0 | | Laskey Johnson Ho | | | | | rive, Ro | | | | 20850 | |
| Ď | | | 20a. Method of Disposition | wald/Wile | | | | | | | cation - City or | - | |
| Dalumore, | B 0 | | 1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification 5) | | cemete | ary, crem | atory or other pi | August | 29, 199 | 7 | | | |
| | ortan Injur | | 21. Signeture of Furieral Service Lice | | Montg | omer | y crema | Lorium, | THC. | berr | esda, | Mary. | Land |
| 3 | permit. Pag Depertment Important: If any injury o | | NaielE. | Terry | M00803 | Ro | ckville | ress of Feoility R Inc. Maryla | 300 West | 0M288 | | | |
| | | | 23a. Pert1. Enter the diseese, or com- shock, or heart failure. List only | plications that callsec one cause on each ii | d the deeth. Do | not ente | er the mode of dy | ying, such as card | ac or respiratory | errest, | | Appro | oximate ral Between |
| | Physician | | | | | | | | | | | | t end Deeth |
| | /Medical Examiner | | Immediate Cause (Final disease or condition | Lung | Cancer | | | | | | | 1 1 | Year |
| | LXMIIIIICI | L | resulting in deeth) | a | Due to (or as a | consequ | uence of): | | | | | | Lear |
| | Z # | ine | | b | | | | | | | | | |
| Ś | eath certificate be executed attending physician and for use as the burial-transit | i Examiner | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury | 0. | Due to (or es a | consequ | uence of): | | | | | | |
| ,00700 | rificate b | Medical | that initiated events resulting in death) Last | C | Due to (or as a | consequ | ience of): | | | | |) - | |
| 200 | th ce endii | an | _ | d | | | | | | | | | |
| | the atter hed for u | Sici | Part II. Other significant conditions of | ontributing to death b | ut not resulting i | in the un | derlying cause g | given in Part I. | 23b. Dtd | tobecco | use contribute | to the c | ause of death |
| 2 10 | that the sed by detection | by Physician | | | | | | | 1 🗆 | Yes 2 | □No 3□P | robably | 4 ₹ Unknow |
| 20000 | aw requ is been 2 shoul | Completed | | | | | | | | en autop ormed? | , | eveilable | on of cause |
| | 0 - 0 | Ю | | | | | | | 10 | Yes 2 |) No | 1 🗆 Yes | 2 🗓 No |
| | | Be | 25. Was case referred to medical | | | | | 26. Place of D | eath (Check only | one) | | | |
| | 0 0 | To E | examiner? 1 ☐ Yes 2 ☒ No | Hospital: | ent 2 ER/O | utpatient | 3 DOA | Wher: | Home 5□ Res | | Other (Spe | ecify) | |
| 5 | | | 27. Menner of Death | 28e. Dete of Inju (Month, Da | iry 28b. | Time of Injury | 28c. Inj | | 28d. Describe | | | | |
| 2 | Attending In death. | atio | 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation | | y roury | mjury | | ☐ Yes 2 ☐ No | | | | | |
| | al or Attendest s efter dest il Director: ed in by the | Certification: | 3 Suicide 6 Could not be determined | 28e. Place of Inj building, etc | | arm, stre | et, factory, office | 9 | | (Street and wn, State) | Number or R | ural Route | Number, |
| | To the Hospital or Attend within 24 hours effer deatl To the Funeral Director: completely filled in by the | edicai (| 29a. Certifier 1 | yelctan: To the best of linar: On the basis of and menner sta | t examination er | e, death nd/or inve | occurred at the astigation, in my | time, date and ple opinion, deeth oc | ce, end due to the curred at the time, | ceuse(s) dete and | and manner as place, and due | s stated. | luse(s) |
| | Vithir Forth | M | 29b. Signeture and title of certifier | | | - | 29c. Licer | nse number | | 29d. Date | signed (Mont | th, Day, Y | 'ear) |
| | 041 | | 00. | -m |) . | | 7. | / 3.5.7 | | Δ110110 | + 26 | 1907 | |
| (| | - 1 | 20 Name and | 1 | leath / | /T | | 4157 | | nugus | t 26, | 177/ | |
| | | | | completed cause of d | | | | | | | | | |
| | | | Ira Berger, M.D. | | | | | , Rockvi | lle, Mar | yland | 2085 | 1 | |
| | Sta | ite | 31. Date filed (Month, DAY 162 9 | 1997 32. Hegist | ar's Signature | 10 | m. 2.00. | | | | | | |



State of Maryland / Department of Health and Mental Hygiene 97 27170

| | | | | | Certifica | te of | Death | | Reg | No. | | | |
|---|----------------|--|---|---------------------|--|------------------|-----------------------------|-------------------------------|--|----------------------|---------------------------|-------------------------------------|--------------|
| D1 | | 1. Decedeni's Name (First, Middle, Las | st) | | 187 18 | 112 | 0,30 | 2. | Data of Death Month | 34510 | Vace | 3. Time | of Death |
| Physic /Med | | THERESA M. HIL | LYARD | | | | | Au | igust 22 | Day 199 | Yeer 7 | 11:0 | 00 PM |
| Exami | | 4a. Facility Name (If not institution, give | a street and number) | | | | 4b. City, To | | tion of Death | 4c. County | of Death | | |
| | | Holy Cross Hospi | tal | | | 9 | | Sprin | | | gome | ry | |
| Funeral | п | Social Security Number 6. Social Security Number | ex 7. Ag | a (In yrs. last bir | Months | r 1 Year Days | | 24 Hrs. 8. Min. | Data of Birth (Month, Day, Ye | ear) | 9. Birthp Coun | lece (State | e or Foreign |
| Director | 8 | 578-18-7491 | UMI ZUXF | 98 | Yrs. | | | Ja | an.13,18 | 99 | Aust | | |
| pur * | | Usual Residence of Decedent 10a, Stete 10b, County | | 10c. City, Tow | n or Location | | | | | | 1 | Od Incido | City Limits |
| eho eho | 20 | | | C90 W 1024 | | | | | | | | | es 2 No |
| burs after death with the Marylan al', or items 23s or 28s-f ehow | Director | Maryland Montgom | ery | Si. | Lver Spr | | | | | 000 | | | 263110 |
| with w | | | | | | Code | | | 10g. | Citizen of | | itry? | |
| s 23 | Funeral | 605 Woodside Park | | Free la III C | 1 | 0910 | | 1-1-0-104 | | U.S.A | | an India. | |
| Herri Herri | S | 11. Marital Status 1 ☐ Navar Married 2 ☐ Married | 12. Was Decedant | | 13. Was Dece | cify Cub | an, Mexica | n, Puerto Ric | an, etc.) | | ce - Americ ck, White, | | |
| d within 72 hours afgiena. Ir than "netural", or | by | 3 Navai Married 2 Married | 1 ☐ Yes 2 ☑ 1 If Yes, Give Yaar or Dates: | 40 | 1□ Yes | 2∰ No | Specify: | | | Specif | | | |
| within 72 hours after death with the Maryland ana. than "netural", or items 23e or 28e-f show the Marical East interference in the residence. | | 15. Decedent's Ed | | 16a | Decedent's Usu | ai Occui | nation | | 161 | b. Kind of B | | lite | |
| in 72 h | Completed | (Specify only highest grad | de completed) | | (Give kind of we life. DO NOT | ork done | during mos | at of working | 101 | 3. 14mg 01 B | doi:1000#1110 | Justiy | |
| filed within Hygiena. other than | E | Elementery/Secondary (0-12) | College (1-4or 5 | i+) | Homemak | | | | | own Ho | am o | | |
| | | 17. Father's Nama (First, Middle, Last) | | | HOMEMAR | | 18. Mothe | er's Name (F | First, Middle, Mai | | ***** | 77.72 | |
| Mental Mental arked o | To Be | Anton Ert1 | | | | | M- | arie | Stampfe | 1 | | | |
| SPEE | - | 19a. Informant's Neme/Relationship (7 | Type, Print) | 19b | . Mailing Addres | s (Stree | t and Numb | er or Rural R | Route Number, C | itv or Town. | State. Zip | Code). | |
| and 2 ealth ar | | Audrea H. Gue | | | | | | | Silver | | | | |
| other tr | | 20a. Method of Disposition | | 20b. Piaca of | Disposition (Na | me of | | | | . Location | - | | |
| Pagas nent of mt: If it | | 1 Burial 2 Cremation 3 | | | ry, crematory or | | | | | 100 | 12. 5 | | 100 |
| permit. Pagas 1 ar Department of Hea mportant: If Item: Iny Injury or othe | | 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen. | | Gate | 22. Name a | | | | 27/97 S: | Liver | Spri | ng,Ma | rylar |
| permit. Page Department of Important: If any injury or once. | | A 151 | 0 | | | | | | neral Ho | ome,] | Inc. | | |
| 2.0 | | Ollew to | and . | Internal De | 500 Uni | yer | sity I | 31vd., | W., Silve | er Spr | cing, | | |
| | н | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only | one cause on each lin | ne. | not enter the mo | ae or ayı | ng, such as | cardiac or re | espiratory arrest | | | Approxim Interval B Onset and | Between |
| Physician /Medical | н | immediate Cause (Final | | | | | | | | | 1 | Chiso, and | 1 |
| Examiner | в | disease or condition rasulting in death) | a. 26 | PSIS | | | | | | | | 4 9 | lays |
| | je je | | | Dua to (or as a | consequence of) | : | | | | | | |) |
| nsit | Examiner | | b | | | | | | | | | - | |
| al-fra | xa | Sequentially list conditions, if any, leading to Immediata | | Due to (or as a | consequence of) | | | | | | | | |
| certificate be asscuted ding physician and ise as the bunal-transit | | cause. Enter Underlying Cause (Disease or Injury that Initiated events | c | D | | | | | | | 1 | | |
| ficate phy street | edical | resulting in death) Last | | Dua to (or as a | consequanca of) | | | | | | | | |
| death certifica attending ph | 3 | | d | | 1007/001 | | | 1000 | | | | | |
| death c | Physician | Destil Other elembiases and title as a | | | | | | | ook Distant | | | | |
| tha c | Jys | Part II. Other aignificant conditions co | ontributing to death bi | ut not resulting if | the underlying | cause gr | ven in Par | 4. | 23b. Did toba | _/ | | | |
| es that igned b | by Pi | Ocstront | rsq.vc | 6/4 | ed.n | | | | 1 🗆 Yes | 2 MO | 3 Proi | Dabiy 4 | Unknow |
| sicien: The law requires to certificate has been signe rector, page 2 should be | | | | | | 7 | | 4 | 24a. Wes an a | | 24b. W | ere autops | y findings |
| been signature | Completed | THE CALL ALE | | | | | | | performe | d? | CO | mpletion o | or to |
| The law ate has b page 2 sl | du | | | | | | | | | _/ | | death? | |
| n: The icate h | | | | | | | - VI | | 1 Yes | 2 PNo | 1 | Yes 2 | .□ No |
| ician: The certificate rector, pag | Be | 25. Was case referred to medical axaminar? | Hospitel: | - Carlotte | | Ot | her: | | Check only one) | 100 | | | |
| this ald | 10 | 1 ☐ Yas 2 ☐ No 27. Manner of Death | 1 ☑ Inpatie | | | UA | 4 L N | | 5 Residence d. Describe how | | | (N | |
| ling After fune | ion | 1 □Natural 5 □ Pending | (Month, Day | | njury M | 28c. inju Wo | rk?]Yas 2□ | | 2. Describe now | injury occur | 100 | | |
| or Attending after death. Director: After d in by the fune | Certification: | 2 Accident investigation 3 Suicide 6 Could not be | | uni Athoma fa | | | 143 2 | | . Location (Street | at and Numi | her or Bure | I Route M | umbar |
| 5455 | i i | 4 ☐ Homicide determined | 28e. Placa of Injude | c. (Spacify) | rm, street, facto | у, опісе | | 201 | City or Town, S | | Der Or Hura | I HOUSE IVE | uniber, |
| ours a | | 500 Continue of 0 111 in | | | | | | | | | | | |
| To the Hospital within 24 hours a To the Funeral C complataly filled | edicai | (Check only 2 Medical Exam | ysician: To the best of ninar: On the basis of | examinetion en | , death occurred d/or investigation | at tha ti | me, date ar opinion, dea | nd place, and ath occurred | f due to the caus et the time, date | e(s) and mand plece, | enner as s | tated. the cause | e(s) |
| the the | Med | one) | end manner sta | ited. | | | se number | | | Date signe | | | |
| | | 29b. Signatura and title of cartifier | (11.10 | | 25 | - | | | | | | 1100 | |
| 12 | | Low | Trace | m | 2 | 3 | 068 | 2 | H | NS " | ST - | 13, 1 | 997 |
| | 186 | 30. Neme and address of person who o | completed cause of d | eeth (item 23e) | (Type, Print) | | 1. | 0 1 | | | | , | |
| | | Moneiy Co | 19perc | 12/8/12 | Ver | 5 1 | n, 11 1 | ۲۵. | Wheat | ں سو | י ניי | 4260 | 20 |
| St | ate | 31. Date filad (Month, Ry 1922 5 | 1997 32. Regist | ar's Signature | - | | | | | | | | |

| | | | | State o | | and / Dep | | of I | Health a | and N | • | ygiene | 77 2 | 27171 |
|--------------------------------|--|------------------|---|---|----------------------|------------------------------------|--|-----------------|------------------------------|-----------------------|-------------------------------|---------------------------------------|--|--|
| | Physic /Medi | cai | Decedent's Name (First, Middle, La CATHERINE | В. | | IGGINS | | | Ab City To | o.l | | 21, 19 | | 3. Time of Death 1:25 PM |
| q | Exami | ner | 4a. Facility Name (If not institution, giver HOLY CROSS HOSPI) | | m <i>ber)</i> | | | | SILVE | | ocation of Dea | | y of Death GOMERY | |
| | Funeral Director | | 104-22-3043 | Sex I□M 2∏ F | 7. Age (In y | rs. lest birthday) Yrs. | If Undar Months | 1 Year Days | if Under | | 8. Data of B | | 9. Birthpla Count | ace (State or Foreign ly) Lssippi |
| | Maryland -f show | tor | Usual Residence of Decedent 10a. State 10b. County PA Luzerne | | | City, Town or Lo | | | | | | | 10 | d. inside City Limits |
| | or 28s | Director | 10e. Street and Numbar | | | | 10f. Zip | Code | | | | 10g. Citizan of | What Count | ry? |
| | ath w | rai | 238 South Grant S | | | | | 3702 | | | | | d Stat | |
| 020 | Juitin 72 hours efter death with the Maryland jiena. r than "natural", or itema 23a or 28a-f show the Modical Examinat must be notified at | by Funeral | 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. Was Dece Armed Fo 1 Ves If Yes, Giv Year or D | rcas? 2 XNo /e | - | Was Daced If Yes, spec 1 ☐ Yas 2 | | | gln? (Sp n, Puerto | pecify Yas or No Rican, etc.) | Speci | ce - America ack, White, e fy: Wh | |
| 5-0 | | etec | 15. Decedent's Ed (Specify only highest gra | ducation de com <i>pleted)</i> | | (Give | dent's Usue | k done | during mos | t of worl | king | 16b. Kind of E | Business/Inde | ustry |
| 2121 | filed within Hygiena. other than | Completed | Elementary/Secondary (0-12) | College (1 | 4-4or 5+) | | <i>cator</i> | a retire | ed) | | | Public | c Scho | ol System |
| pu | 2 5 P | Be | 17. Father's Name (First, Middle, Last, |) | | | | | 18. Mothe | er's Nem | e (First, Middl | e, Meiden Sume | me) | |
| 7 | | 2 | John Heffron | | | | | | E11 | - | McDo | | | |
| Mai | 12 S | | 19e. Informent's Name/Relationship (| ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | | | | | ber, City or Town | | |
| Baltimore, Maryland 21215-0020 | Pages 1 and 2 nent of Heelth int: If Item 27 i | | James P. Higgins, 20a. Method of Disposition 1 \(\bar{\text{M}}\) Burial 4 \(\text{Cremation} \) 3 \(\text{Cremation} \) 4 \(\text{Donaylor} \) 5 \(\text{Other} \) (Specify | Removal from | State | Place of Disponentery, cre | osition (Nem matory or ot | e of her ple | ece) | A | Date ug. 25 1997 | es-Barre 20c. Location Hanove | - City or Tov | |
| Balt | permit. Page: Department or Important: If I any Injury or once. | | 21. Signature of Funaral Service Licer | 100 | | | | | ass of Facilit | . 1 | | uneral Washin | Home | DC 20007 |
| | Physician | | 23a. Part 1. Enter the diseast e, or com shock or heart failure. List only | | | | | | | | | | | Approximate Interval Between Onset and Death |
| | /Medical Examiner | | Immediate Cause (Final disaase or condition resulting in death) | · 70 | B MA | RAC+ Oras a conse CNAM | quence of): | 1 1) | £16 | 200 | 0 FR 4/1 | 3 C E | 0 | LOAYS |
| | uted d ansit | Examiner | Securation like the security of | b | | C NA N | | M. | 165 | KSE | Eur | 101 | | Years |
| ,092 | te be executed ysician and ne burial-transit | cai | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or injury that initiated events | c | Col | QCUL (or as a consec | 0 | A | 747 | 1 | | | | |
| Box 68 | eath certificate attending phys I for use es the | n/Med | resulting in death) Last | d | | ` | | | | | | | | |
| P.O. | that the died by the deteched | y Physician/Medi | Part II. Other significant conditions o | ontributing to de | eath but not r | esulting In the u | nderlying ca | use gi | iven in Part I | ļ, | | tobacco use c | ontribute to | the cause of death |
| Records, | aw requir | Completed by | | | | | | | | | 24a. Wa | s an autopsy formed? | con | ra autopsy findings ilable prior to apletion of causa eath? |
| | 0 2 0 | Con | | | | | | | | | 1□ | Yes DNo | 10 | Yes 2□ No |
| Vital | ysician: The second second director, page | Be | 25. Was case referred to medical examiner? | 11 - 2 - 1 | | | | | | of Dee | th (Check only | one) | | |
| ō | Phys | lon: To | 1 Yes 2 No 27. Menner of Death 1 Death 5 Pending | 28a. Date of | | ER/Outpatie | f 28 | Bc. Inju | iry at ork? | | | how injury occu | |) |
| Division | | Certification: | 2 ☐ Accident investigation 3 ☐ Suicida 6 ☐ Could not be 4 ☐ Homicide determined | e 28e. Placa | of Injury - A | t home, farm, st | M reet, factory, | | Yes 2 | NO | | (Street end Num own, Stete) | ber or Rural | Route Number, |
| | Hospital 4 hours Funeral tely filled | edical C | 29a. Certifier (Check only one) Certifying Ph | niner: On the be | esis of exami | nowledge, deat nation and/or In | h occurred a vestigation, | t the ti | ime, dete an opinion, dea | d placa, th occur | end due lo the | a ceuse(s) and n o, date and place | nanner as sta , and due to | ited. the cause(s) |
| | To the vithin 2 To the complete | Mec | 29b. Signature and title of certifier | and manr | er stated. | | 290 | Licen | se number | | | 29d. Date sign | ed (Month f | lav. Year) |
| | 17 E3E8 | | | | | | 200. | 1 | 100 | 21 | | C) 8/21 | 1186 | 7 |

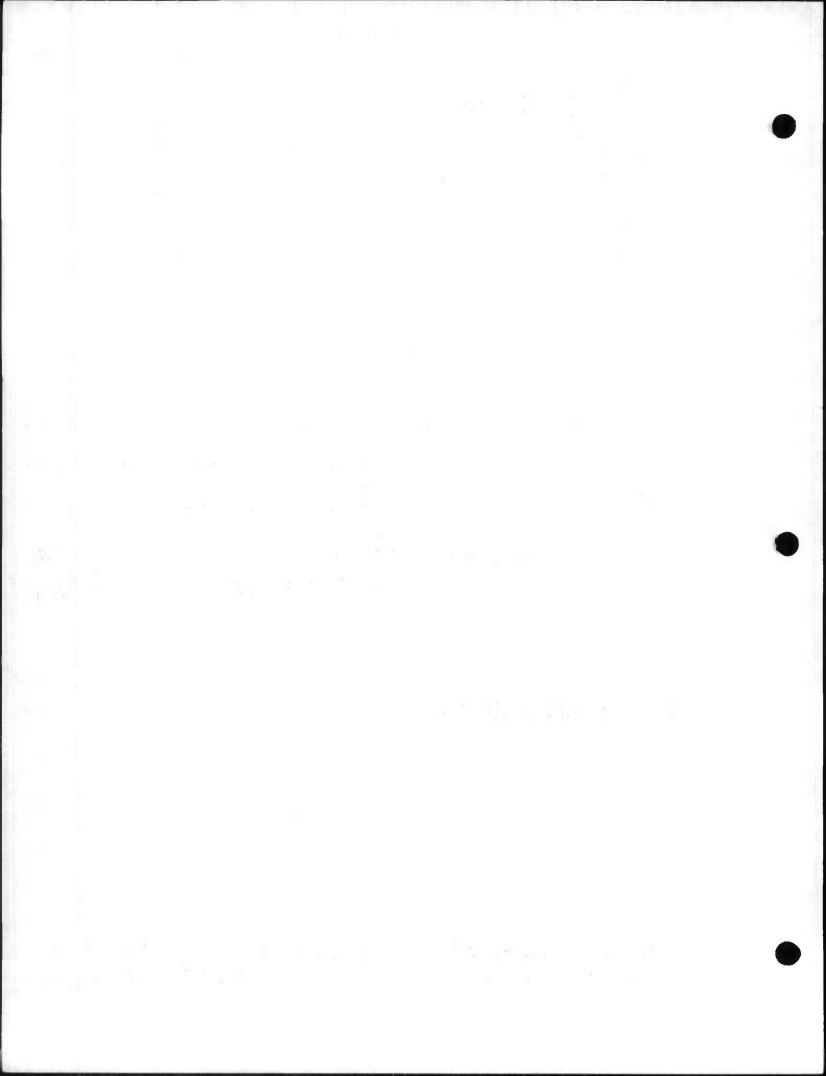
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. SVD HAKAR. 7610 CARPOLL ATE

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

State of Maryland / Department of Health and Mental Hygiene

| | | | Certificate of Death | | ı. No. | |
|------------|---|--------------------------|---|---|---|---|
| 1 | Physic | ion | 1. Decedent's Neme (First, Middle, Last) | 2. Dete of Death Month | Day Year | 3. Time of Death |
| | /Medi | | Catherine B. HICKS | August 2 | • | 7:05 AM |
| | Exami | | 4e. Fecility Nama (If not institution, give street end number) 4b. City, Town, o | r Location of Deeth | 4c. County of Death | |
| | | | Carriage Hill of Silver Spring Silver S | nrino | Montgome | *17 |
| | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yaar If Under 24 Hr | rs. 8. Date of Birth | 9. Birth | place (Stete or Foreign intry) |
| | Director | | 578-32-2484 1□M 2໘F 89 Yrs. Months Days Hours Mill | March 17, | | York |
| | land | | 10a. State 10b. County 10c. City, Town or Location | | | 10d. Inside City Limits |
| | death with the Maryland ms 23s or 28s-f show | to | Maryland Montgomery Rockville | | | 1 TYas 2 □ No |
| | 7 28e | <u>e</u> | 10e. Street end Number 10f. Zip Code | 100 | . Citizan of What Cou | intry? |
| | 3a o | 0 | 7208 Old Gate Road 20852 | | U.S.A. | |
| | deat | ner | 11 Marital Stetus 12. Was Decadent Ever in U.S. 13 Was Decadent of Hispanic Origin? | | 14. Race - Amer | |
| 21215-0020 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygione. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Madesi Evantment inside to notified a once. | by Funeral Director | Armed Forces? 1 Never Married 2 Married 1 Yes, Specify Cuban, Mexican, Pue 1 Yes, Sive 1 Yes, Sive 1 Yes, Specify: 1 Yes 2 No Specify: Yes or Dates: | erto Hican, etc.) | Black, White | |
| 9 | 2 hor | Completed | 15. Decedent's Education 16a. Decedent's Usual Occupation | 16 | b. Kind of Business/li | iite ndustry |
| 215 | within 7 ene. than "n | ple | (Specify only highest grada completed) (Give kind of work done during most of w life. DO NOT use retired) | rorking | | |
| 2 | d with giene. rr than | E | 12 Clerical | F | ederal Gov | ernment |
| pu | be filed tal Hygie d other event, II | Bec | 17. Father's Name (First, Middle, Last) 18. Mother's New | eme (First, Middla, Ma | iden Sumeme) | |
| /a | Menti Menti arked arice | To | John H. Bailey Marga | ret LaVe | 11e | |
| Maryland | 2 should be and Mental is merked o aumetic eve | ľ | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Number or F | Purel Routa Number, C | City or Town, Stete, Z | p Coda) |
| | 1 and 2 Health em 27 i | | Mary P. McCarthy 7208 Old Gate Raod | Rockville, | Maryland | 20852 |
| ore | of He | | 20a. Method of Disposition 20b. Place of Disposition (Name of | | c. Location - City or T | |
| Ĕ | Pages nent of I ant: If ite ary or of | | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery | 8/29/97Si | lver Sprin | g.Marvland |
| Baltimore, | permit. Page Department of Important: If any injury or ance. | | 21. Signature of Funaral Service Licensee 22. Name and Addrass of Facility | | | |
| m | 82558 | | Francis J. Colling 500 University Bl | | | |
| | 17-1-1 | | 23a. Pen1. Enter the disease or complications that caused the daath. Do not enter the mode of dying, such as carding shock, or heart failura. List only one ceuse on each line. | ac or respiratory erres | ver spring | Approximate |
| ш | Physician | | | | 1 | Interval Batween Onsat and Death |
| | /Medical | | Immediate Couse (Final disease or condition rospiratory tail U/e | | | MMediate. |
| | Examiner | | Immediate Ceuse (Final disease or condition resulting in death) a. respiratory failure Dua to (of as a consequenca of): Metastatic breast cance | | | 1000- |
| | P # | ine | Metastatic breast cana | efr | | Standers |
| | tificata be axecuted g physician and as the burial-transit | Examiner | | | | |
| 90, | oe ax | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events | | | |
| 68760, | hysk the t | edical | that initiated events Due to (or as a consequence of): | | | |
| | E 0 6 | | d | | | |
| Box | attendin | ian | | | | |
| P.O. | the de | yslc | Part II. Other algrificant conditions contributing to death but not resulting in the underlying cause given in Pert I. | 23b. Did tobe | ecco use contribute | to the cause of death? |
| | The law requires that the death cer ate has been signed by the attendir page 2 should be datached for use | Completed by Physician/N | Gall Bladder Wiseuse | 1 Tyes | 2 □ DN6 3 □ Pro | bably 4 Unknown |
| Records, | quira: n sig uld b | 8 | | 24e. Was en | | Vare autopsy findings |
| 00 | w rek | olet | | performe | 0 | vailable prior to ompletion of ceusa f death? |
| R | The lav | E | | 1□ Vo. | | □Yes 2□No |
| Vital | | | 25. Was case referred to medical 26. Place of Dr. | eath (Check only one) | 28140 | |
| > | | o Be | axaminer? Hospital: | Home 5 Rasidence | a 6 Other (See | (6.1) |
| of | Phys aral d | n: T | 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury et | 28d. Describe how | | 777 |
| o | tending Ph leath. tor: After th the funaral | 35 | 1 ☐ Matural 5 ☐ Pending (Month, Dey Year) Injury Work? 2 ☐ Accident invastigation M 1 ☐ Yas 2 ☐ No | | | |
| Division | Attending or death. | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica | | et end Number or Rui | re / Route Number, |
| ā | s after | Sert | 4 Homicide building, etc. (Specify) | City or Town, | 5(0(0) | |
| | To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After complataly filled in by the funar | edical (| 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledga, daath occurred at the time, date end place (Check only one) | ce, end due to the caus curred at the time, date | se(s) end manner ss and piece, and due | stated. to the cause(s) |
| | Fo th withir | Me | 29b. Signature and tale of certifier 29c. License number | 29d | . Date signed (Month | Day, Year) |
| | 3 | | 1 - Wull 1 - MU 17142 | - Du | gust 24 | 1,1992 |
| | 1 | | 30. Name and addrass of person who completed eduse of death (Item 23a) (Type, Print) | 2 | 1 | 11107 |
| | | | 30. Name and address of person who completed eduse of death (Item 23a) (Type, Print) La Ptw Ketting MO ZIDI Medical Po | W Milli | No Stry | Spring 2040 |
| | Sta | te | 31. Date filed (Month, Auto) 8 1997 12. Registrar's Signature | 1 -10 -10 | | 1 /0 10 |
| | Registr | 200 | Juna way don- Mandell | | | |



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2 Date of Death 3. Time III Death Month **Physician** HICKMA 2050 DHN HOMAS AUG /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 20501 Lowfield Drive Germantown Montgomery If Undar 24 Hrs. 8. Deta of Birth (Month, Dey, Year) 5. Sociel Security Number If Under 1 Yaar 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1283 M 2□ F Months Days Yrs. Director 217-72-9036 41 June 9, 1956 Washington Usual Rasidance of Dacedant Maryland 10a. Stata 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. insida City Limits Director 1 ☐ Yas 2 ☑ No Maryland Montgomery Germantown the 10e. Street end Numbar 10f. Zip Coda 10g. Citizan of What Country? 20501 Lowfield Drive death Funeral 20874 United States 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 2200 o If Yas, Giva Yeer or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian, Biack, White, etc. 11. Meritai Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: p 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedant's Education (Specify only highest grade completed) 18a. Decedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry I filed within 72 I Hygiene. Elamantary/Secondary (0-12) College (1-4or 5+) 4 permit. Pages 1 and 2 should be filed in Department of Heelth and Mental Hygis Important: If item 27 is marked other tenty injury or other traumetic event Supervisor Transportation 17. Father's Nema (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surname) Be 2 John Thomas Hickman Marylou Ellen Bright 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian A. Hickman (Wife) 20501 Lowfield Drive, Germantown, MD 20874 20e. Mathod of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☑ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Metropolitan Crematory 8/22/97 Alexandria, Virginia DeVol Funeral Home 21. Signatura of Funerel Sarvica Licensea 22. Nema and Addrass of Facility D. Hilbons 10 East Deer Park Drive Gaithersubrg, MD 20877 23a. Pert. Entar the disaasa, or complications that ceused the death. Do not entar the mode of dying, such as cardiac or respiretory errest, show, or heart feilure. List only one ceuse on each line. Approximete Intarval Batween Onsat end Death **Physician** /Medical Immediete Causa (Finel WOUN diseasa or condition resulting in death) Examiner Due to (or es e consequança of): Examiner burial-transit Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Disaasa or injury that initiated avants resulting in daath) Lest Due to (or as a consequance of): Box 68760, The law requires that the death certificate be Physician/Medical the Dua to (or as a consaquanca of): 80 ettending for use es 9SF Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? the detach 2 1 Yes 2 No 3 Probably 4 Unknown signed be del Records, Completed by 24b. Wara autopsy findings aveileble prior to complation of causa of daath? 24a. Was an autopsy performad? peed page 2 No certificate 1 Yas 1 ☐ Yas 2 ☐ No of Vital To the Hospital or Attending Physician: within 24 hours effer deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director, I Be 25. Was casa rafarred to medical 26. Place of Death (Check only one) axaminar? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Rasidence 8 Othar (Specify) P 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury et Work? 28d. Dascribe how injury occurred 28b. Tima of Certification: Division 5 Panding investigation 1 Naturel V621972045 2/2 No 1 ☐ Yas IN 2 Accidant 5401 3 Suicide 4 ☐ Homicide 6 ☐ Could not be datarmined 28a. Place of injury - At home, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) House 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2 Hadical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and menner stated. 29a, Certifier Medicai (Check only one)

29c. Licensa number

FERYWOOD &

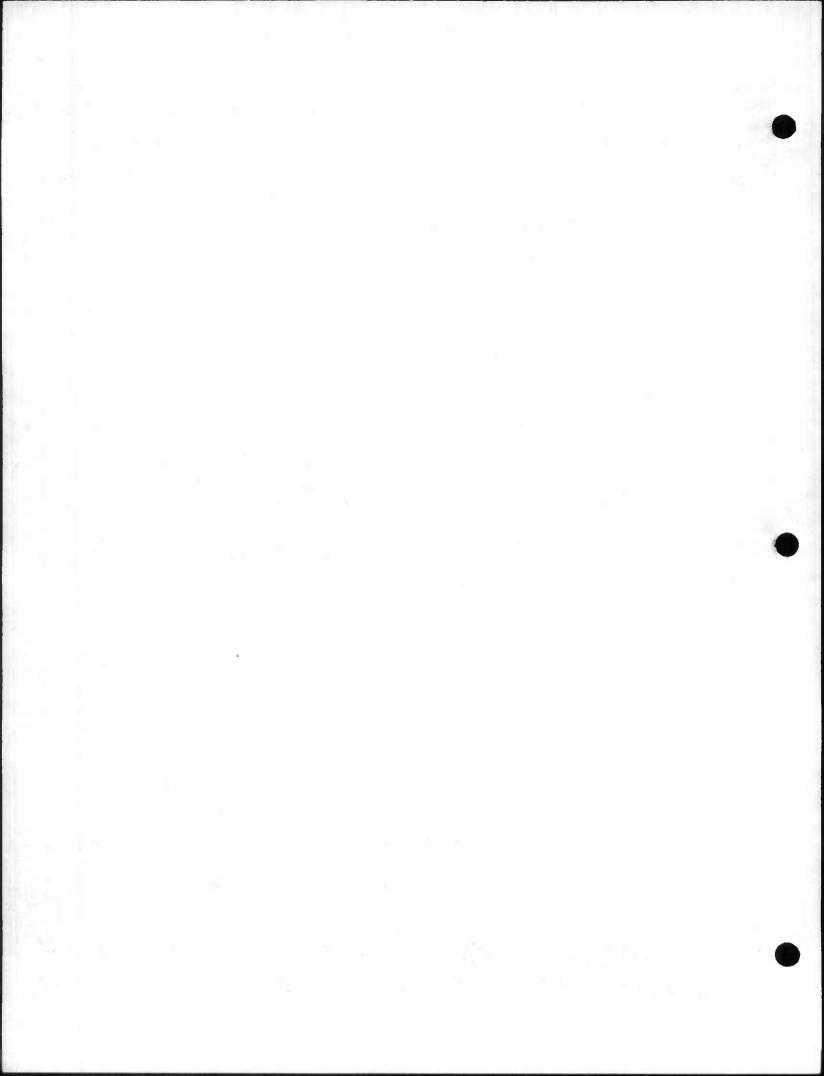
completed cause of deeth (Itam 23a) (Type, Print)

9/6 10 HS FE

29d. Data signed (Month, Day, Year)

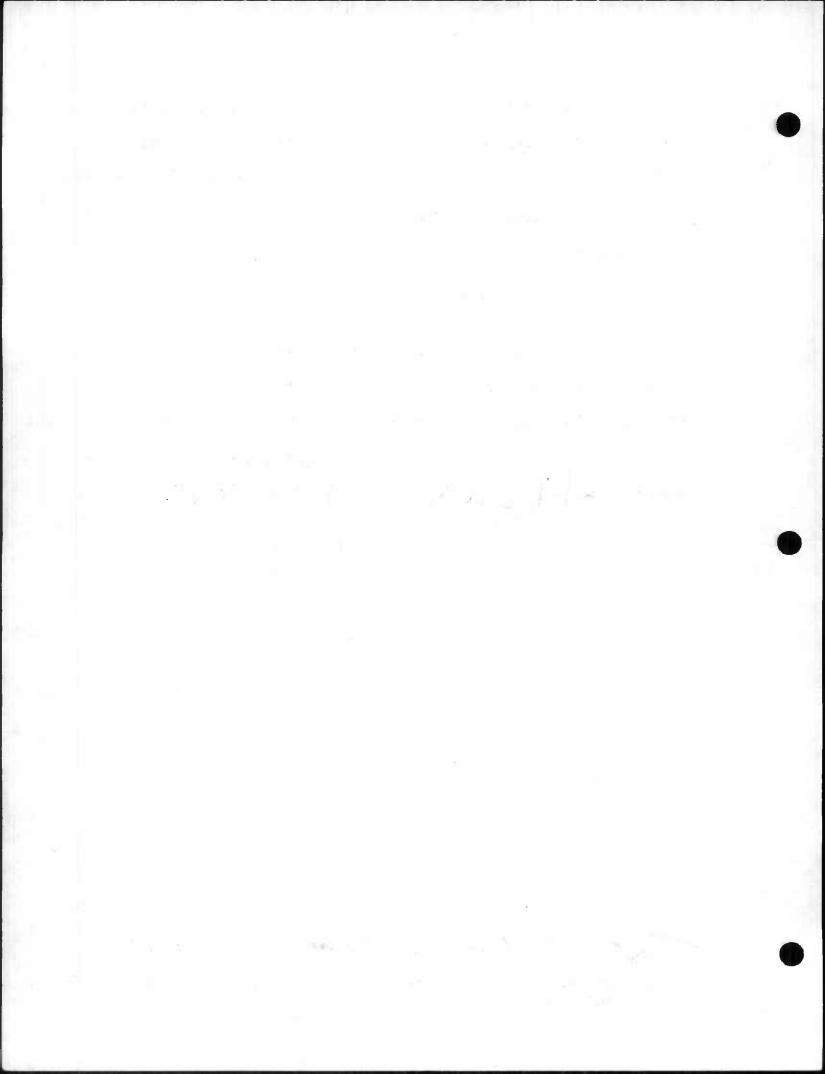
State Registrar 29b. Signatura and title of certifian

FRAN CLS



State of Maryland / Department of Health and Mental Hygiene 97 27174

| | | | | | Cer | tificate of | f Death | | Reg. No. | 1 6 | |
|---|------------------|---|---|---------------------------------------|-------------------|--|---|---|------------------------------------|--|--|
| Dhualai | | 1. Decedent's Name (First, Middle, Li | ast) | | | | | 2. Date of De | - | Year | 3. Time of Dea |
| Physici /Medi | | Willia | m Helle | r | | | | Augus | | 1997 | 4:20a |
| Examir | | 4a. Fecility Name (If not institution, gi | ve street and number | er) | | | 4b. City, Town, or | | | | |
| | | Carriage Hill | Bethes | da | | | Bethes | | Mont | tgome | ry |
| FuneralDirector | | 577-60-4806 | Sex 7. 1XDM 2□F | Age (In yrs. last b | irthday) Yrs. | If Under 1 Yea Months Day | | | th y, Yaar) | 9. Birthpl Count | lace (State or Fol try) York |
| p s | | Usuel Residence of Decedent 10a. State 10b. County | | 10c. City, Tov | m or los | etion | | | | | |
| ahow al at | 7 | Maryland Montg | omory | Bethe | | | | | | 10 | 0d. Inside City Ll |
| Ne N | ecto | | Onery | Derlie | sua | | | | | | |
| ath with the Marylar 23a or 28a-f ahow | Funeral Director | 10e. Street and Number 5215 Cedar Lan | е | | | 10f. Zlp Code 2 0 8 | | | U.S. | | try? |
| Herne Herne | by | 11. Marital Status 1 Never Marrled Marrled 3 Widowed 4 Divorced | 12. Was Decede Armed Force 1 XYes 2 I If Yes, Give Year or Date | \$? | | Ves Decedent of Yes, specify Cu ☐ Yes 2 X No | Hispanic Origin? (S ben, Mexicen, Puer Specify: | Specify Yes or No- to Rican, etc.) | | ce - Americe ck, White, e y: Whi | etc. |
| 72 hours natural, | Completed | 15. Decedent's E (Specify only highest gr | ducation | 168 | . Deceda | ant's Usual Occi | upation e during most of wo ed) | rkina | 16b. Kind of B | usiness/Ind | lustry |
| within ena. | ď | Elementary/Secondary (0-12) | Collaga (1-4c | N 3+1 | | | | ring . | | 19 | |
| your that | ပိ | | 4 | A | ppe | llate | Auditor | | I.R. | S. | |
| d out | Be | 17. Father's Name (First, Middle, Last | * | | | | | ma (First, Middle, | | ne) | |
| Men | To | Nathan Isidore | Heller | | | | Lotti | e Belsk | У | | |
| and 2 should be filed within 72 hours after alth end Mental Hygiena. 27 is merked other than "natural", or per traumatic event, the Massell Example. | | Jean F. Heller | | | | | et and Number or Ri rk Ave. | | | | |
| permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiana. Important: If Item 27 is marked other than any Injury or other traumatic event, the Magnee. | | 20a. Method of Disposition 1 ☑ Bunal 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci | N/ | IO / | ngt | on Nat Name and Add | ional 9/ | | Arling | | |
| 88 2 2 8 | \leq | Jacon J | All | la | | | arson Fi | | | , VA | 2220 |
| Physician /Medical | | Part Enter the disease, or complete the control of | | | | | | or respiratory ar | rest, | | Approximate Interval Between Onset and Death |
| Examiner | | diseasa or condition resulting in death) | a. Asp | iration | - | | a | | | | days |
| | ē | | | Due to (or as a | | | | | | | |
| nsit | 듵 | | b. Alz | heimer' | | | | | | | years |
| ntificata be executed ng physician and s as the buriel-transit | ai Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or injury that initiated events | C | Due to (or as a | consaqu | ience of); | | | | | |
| certificata ding phys se as the | /Medical | resulting In death) Lest | d | Due to (or as a | consequ | ence of): | | | | 1 | |
| eath ce ettandi | Physician/ | | | | | | | | | | |
| the d | ysi | Part II. Other algnificant conditions of | contributing to deeth | but not resulting I | In the und | derlying ceuse g | iven in Part I. | 23b. Did t | obacco use co | ntribute to | the cause of de |
| es that the death ce igned by the ettand be deteched for us | by Ph | | | | | | | 101 | Yes 2 No | 3 Prob | ably 4 Unki |
| aw requir | Completed | | | | | | | | an autopsy med? | com | ere autopsy findin illable prior to inpletion of cause death? |
| | ပို | | | | | | | 1 🗆 Y | es 2 No | 10 | Yes 2 No |
| ysician: The s certificate director, pag | Be | 25. Was casa raferred to medical axaminer? | | | | | 28. Place of Dar | ath (Check only or | na) | | |
| 5 00 | 2 | 1 ☐ Yes 2 No | Hospital: 1 ☐ Inpa | | utpatient | 3□ DOA O | ther: 4XNursing h | loma 5 □ Resid | lence 8 DOth | er (Specify |) |
| of feet | Certification: | 27. Mannar of Death 1 ☑Natural 5 ☐ Panding 2 ☐ Accident Investigation | | jury 28b. | Tima of Injury | M 1 E | uryat ork?]Yes 2 □ No | 28d. Describe h | ow Injury occur | red | |
| il or Attandil after death. I Director: A d in by the fu | ertific | 3 Suicide 6 Could not b datermined | Zoa. Place of I | njury - At home, fa etc. (Specify) | arm, stree | et, factory, office | | 28f. Location (S City or Tow | | er or Rural | Route Number, |
| To the Hospital o within 24 hours af To the Funeral DI completely filled in | edical | 29a. Certifier (Check only one) 1⊠ Certifying Ph | ysician: To the bes | of examination an | e, death o | occurred at the testigation, in my | ime, data end place opinion, daath occu | , and due to the c rred at the tima, c | cause(s) and ma data and place, | innar as sta and dua to | ated. tha cause(s) |
| omp of the | Me | 29b. Signeture end title of certifier | | VIA-11-0 | | 29c. Licen | ise number | 2 | 29d. Date signe | d (Month, E | Day, Year) |
| | | Mari | (0) | ele | | D394 | | | 8/25/ | | 7 |
| 20 | 1 | 08/10 | | v (| | | +30 | | 0/23/ | | |
| - 1 | | 30. Nama and address of person who | | | | | | | | | |
| | | Lila McConnel: | L 5530 N | iscons: | in A | lve. Ch | nevy Cha | se, MD | 2081 | 5 | |
| Stat Registra | e ar | 31. Date filed (Month, AUG 28 | 1997 32. Regis | Paris Signatura Lina Davids | -A | mess | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth Day 23 Month **Physician** tar August 9:30 PM HORN 23, 1997 4c. County of Death /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Name (If not institution, giva street and number) Examiner PRINCE GEORGES HOSPITAL CHEVERLY PRINCE GEORGES If Undar 1 Yaar If Undar 24 Hrs.

Months Deys Hours Min. Birthplece (Stete or Foraign Country) 5. Sociel Sacurity Number 6. Sex 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dev. Year) **Funeral** Months 578-14-6659 Yrs. Director FEB. 12,1925 WASH. D.C. Usuel Residence of Decedent 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 ▼Yas 2 No Director PRINCE GEORGES LEWISDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 238 2006 AMHERST RD. Funeral 20783 U.S.A.

14. Race - American Indien,
Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 № Yas 2 □ No If Yes, Give Yaar or Datas: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxicen, Puerto Rican, atc.) 1 ☐ Never Married 2 ☐ Merried "natural", or 1 ☐ Yes 2 No Specify: à Specify: 3 Widowed 4 □ Divorced BLACK Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda completed) 16b. Kind of Businass/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiena. marked other than Elementery/Secondery (0-12) College (1-4or 5+) 12 CAB DRIVER CAB permit. Pages 1 and 2 should be filit Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumetic event 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be THORNTON DAVENPORT HART CLARA 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) D. HART/DAUGHTER LAURA SAME AS TTEM 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 Cremetion 3 ☐ Ramovel from State 4 ☐ Donetlon 5 ☐ Other (Specify) CHAMBERS CREMATORY 8-26-97 RIVERDALE, MD. 21. Signatura of Funeral Service Licenses 22. Name end Address of Fecility CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 M00091 23a. Part1. Enter the diseasa, or complications thet ceused the deeth. Do not antar the moda of dying, such es cerdiac or raspiretory errast, shock, or heer feilure. List only one ceuse on each line. Approximete Intervel Between Onsat and Death **Physician** /Medical Immediate Cause (Finel RESPIRATORY

Due to (or es e consequence of): disease or condition resulting in deeth) Examiner Examiner physician and s the burial-trans Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Last Due to (or as e consequance of) Physician/Medical Due to (or es e consequance of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yee 2 ☐ No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveilable prior to completion of causa of death? Completed 24e. Wes an autopsy performed? peed 1 Yes 2 DONO 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician: 24 hours after death.
Funeral Diractor: After this certifica stall filled in by the funeral director, p. 86 25. Wes cese referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospitel: Othar: 4 Nursing Home 5 Rasidance 8 Othar (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 5 Pending 1 Maturel 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Suicide 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide

152 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the best of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, and due to the ceuse(s) end menner steted.

30. Name and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

S. T. KAO, MO; GOOO—MITCH (ITEM 23e) (Type, Print)

Read; # 220, Bourie—M—20716.

29c. License number

29d. Date signed (Month, Dey, Year)

Division of Vital

P.O. Box 68760.

Records,

Baltimore, Maryland 21215-0020

To the Hospital of within 24 hours a To the Funeral C completaly filled

State

Medical

29e. Certifier

29b. Signeture end title of certifier

I-RAO, MD

: 4000-Mit

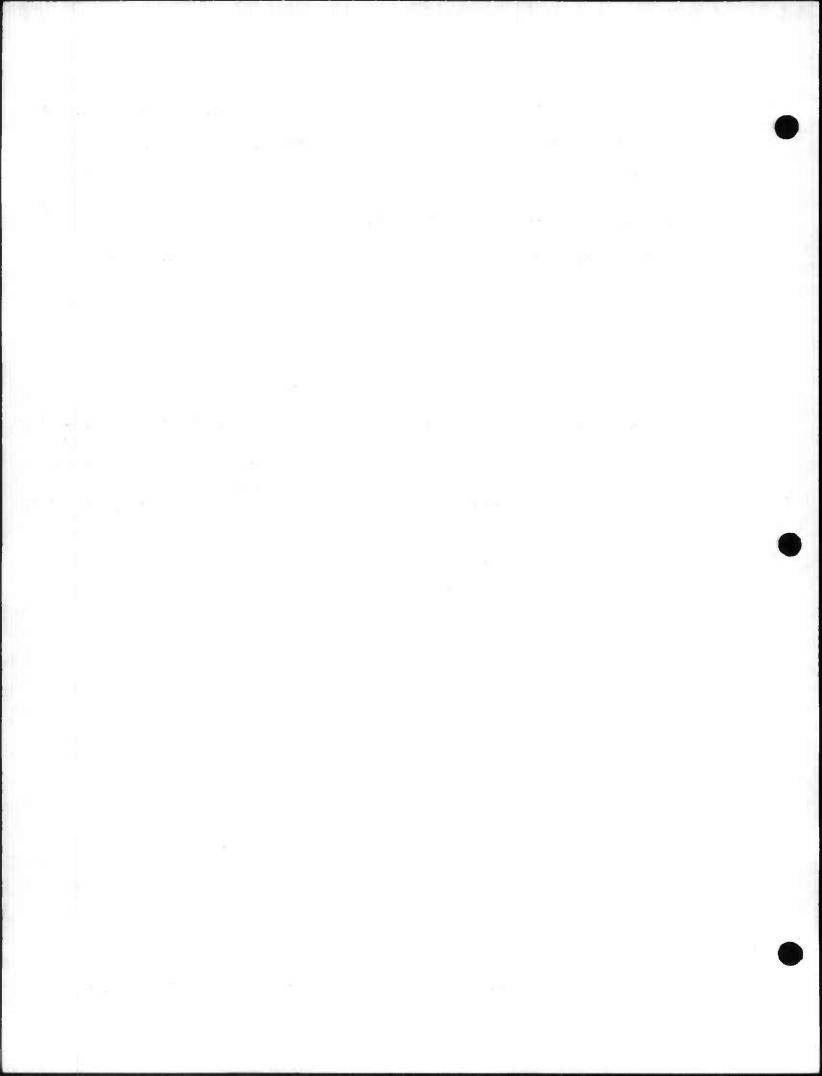
100732. Registrarit Signature

Mark Str. Crim. St. Teage-At and the second of the second o and you was a process of the control of the The transfer of the state of th

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 27 1 7 6

| | | | | | Ce | ertificate of | Death | | Reg. No. | | |
|--|----------------|---|---|--|----------------------------------|---|--|--|------------------------------------|------------------------------|--|
| | | 1. Dacadent's Name (First, Midd | le, Lest) | | | | | 2. Date of D | eath | Walls | 3. Time of Death |
| Physic /Med | | | Wolf | | Haber | | | August | 26, 199 | 97 | 8:00 AM |
| Exam | | 4a. Facility Name (If not institution | | number) | | | 4b. City, Town, o | or Location of Dea | | | 0.00 MI |
| — A | | 13804 Rippling | Brook Dr | rive | | | Silver | Spring | | gomer | V |
| Funera | Т | 5. Social Security Numbar | 6. Sex 1 M 2 □ F | | rs. lest birthday | | r if Under 24 H | rs. 8. Date of B | irth | | |
| Director | | 130-24-9343 Usual Residence of Decedent | 1⊠M 2□F | 67 | Yrs. | Months Days | Hours M | in. (Month, D August 1 | ay, Year) 18, 1930 | | aca (Steta or Foreign ry) rmany |
| Mand Mand | | 10a. Stete 10b. County | | 10c. (| City, Town or L | _ocation | | | | 10 | d. Inside City Limits |
| tha Man 28a-f sh our ad | Director | Maryland Monto | gomery | 5 | Silver | , , | | | | | 1 ☐ Yes 2 🖾 No |
| 23a or | | 13804 Rippling | Brook Dr | ive | | 10f. Zip Code 2090 | 06 | | 10g. Chizen of Unite | d Stat | |
| within 72 hours after death with the Maryland one. than "natural", or items 23s or 28s-f show he Madical Examiner must be notified at | by Funeral | 11. Maritai Stetus 1 Naver Married 2 Mar 3 Widowed 4 Divorced | ried 1 Tyes | | U,S. 13 | . Was Decedent of if Yes, specify Cu | ban, Mexican, Pu | (Specify Yes or N erto Rican, etc.) | | ce - America ck, White, e | |
| d within 72 hours jiena. r than "natural", me Wed cal Exe | Completed | 15. Deceder (Specify only higha | nt's Education st grede complete | d) | 16a. Dec | edent's Usuel Occu e kind of work done DO NOT use retir | upation o during most of w | vorking | 16b. Kind of B | | |
| withir ena. than | Ę | Eiementary/Secondary (0-12) | | (1-4or 5+) | | | 90) | | 11 6 | D | . C T |
| T3 C0 10 000 | | 17. Fether's Name (First, Middle, | | 5+ | | Attorney | 19 Matheric N | eme (First, Middle | | | of Treasury |
| d ta | Be | Max Haber | Lasty | | | | | | | 16) | |
| d 2 should by th and Menta 7 is marked traumatic ex | 2 | 19e. Informant's Name/Relations | thin /Time Reint) | | 10h Mai | ling Address (Stree | | ta Lerner | | Charles 7:5 | 2-41 |
| and 2 sho saith and 1 27 is me or traum | | Dr. Pearl Katz | stilp (Type, Flitt) | Wife | | | | | | | /aryland 2090 |
| it. Pages 1 and 2 rument of Haalth a rum: if item 27 la njury or other tra | | 20a. Method of Disposition 1 ☐ Buriai 2 🛱 Cremation | 3 □Removal from | | . Piace of Disp cemetery, cre | position (Neme of ematory or other pl | ece) | Dete | 20c. Location | | |
| permit. Pages Department of Important: If it any injury or once. | | 4 Donation 5 Other (S | | 7 | 1 | eake Crer | ess of Facility | 8-28-97 | | | |
| Dep | | Male | Vil | lell | / | Rapp Fune 933 Gist | eral Serv | vices, P | .A. Spring | Maryl: | and 20910 |
| | | 23a. Pagt. Enter the disease, or shock, or heart failure. List | complications that only one cause or | caused the de each line. | ath. Do not er | nter the mode of dy | ing, such es card | iac or respiretory | arrest, | | Approximete interval Between Onset and Daeth |
| Physician /Medical | | Immediate Ceuse (Finai | | | | | | | | | |
| Examiner | | disease or condition resulting in death) | a L1 | ver Met | | | | | | | 2 months |
| | ē | | 0. | | (or es a conse | equence of): | | | | | |
| uted | 튵 | _ | b. <u>LO</u> | lon Can | | , , , | | | | | l year |
| oe axect | I Examiner | Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | , | Due to | (or as a conse | equence of): | | | | 1 | |
| eath cartificata be axecuted attending physician and for usa as the bunal-transit | Medical | that Initiated events rasulting in death) Last | | Due to | (or as a conse | equence of): | | | | | |
| death ca e attendi | iclan | Part II. Othor of millione annulate | d. | death but act a | anutain a in Aba | | Contraction Disaster | oot pt | | | |
| that the death | Physician | Part II. Other efgnificant condition | one contributing to | death but not re | esuiting in the | undenying cause g | van in Parti. | | V | | the cause of death? |
| aw requiras ts been sign 2 should be | Completed by | | | | | | | | s an autopsy ormed? | com | e autopsy findings lable prior to spietion of causa eeth? |
| 0 - 0 | 000 | | | | | | | 10 | Yes 2 No | 1 🗆 | Yes 2X No |
| | Be (| 25. Was case referred to medica | 1 | | | | 26. Place of D | eath (Check only | one) | | |
| S 00 0 | 2 | examiner? 1 ☐ Yes 2 🂢 No | Hospitai: | Inpatient 2 | ☐ ER/Outpatie | ent 3 DOA O | ther: 4 Nursing | Home 5 X Res | idence 6 Oth | ar (Specify) | |
| After funa | | 27. Manner of Death 1 Naturel 5 Pendir 2 Accident Investi | ig (Mo | e of Injury onth, Day Year) | 28b. Time injury | W | | | how injury occur | | |
| or Att | Certification: | 3 Suicide 6 Could 4 Homicide determ | not be 28e. Ple | ce of Injury - At Iding, etc. (Spec | home, farm, s | treet, factory, office | | | (Street end Numl wn, Stete) | per or Rural | Routa Number, |
| To the Hospital or Att Within 24 hours after of To the Funeral Direct complataly filled in by | edical C | 29a. Certifier (Check only one) | Examiner: On the | ne best of my kr basis of examir anner stated. | nowiedge, dea nation and/or i | th occurred at the to | ime, date and pla opinion, death oc | ce, and due to the curred at the time | cause(s) and made, date end place, | anner as sta and due to 1 | ited. the cause(s) |
| To the He within 24 To the Fe complata | Me | 29b. Signature end title of certifie | | | | 29c. Licer | se number | | 29d. Date signe | d (Month, D | lay, Year) |
| 15 | |) leter B | Shower | mV | | 0 2 | 4910 | | Allquet | 26 1 | 1007 |
| | | 30. Name and address of person | who completed as | use of death /th | om 22a\ /Turn | | 7110 | | August | 20, | 133/ |
| | | | | | | | Drive | Wheatar | Mass. 1 | nd 01 | 2006 |
| C+ | ate | Peter B. Sherer | 9 0 100 = 32 | Regisfark Sin | enture - | , remara | Drive, | wheaton, | maryla | na 20 | 1900 |
| Regist | | 31. Dete filed (Month, DAUG) | e a 1331 | gunart | avidson- | fandelle. | | | | | |



| | Please | Type or Prin | | | | nk. Assure | | | | ble. 27 | 177 |
|---|-----------------------------|--|--------------------------------|------------------------------|----------------|---|-------------------------------|------------------------------|----------|--|--------------------------------|
| | | State of Mis | ai yiai iu / | | | of Death | ı Memai F | | | I to I | 1 / / |
| 1. Decedent's Nama | (First, Middla, La | st) | | 00111 | nouto | or Douter | 2. Dete of | Reg. No. Death | | 3. Т | Ima of Death |
| Bernice 4a. Facility Nama (If | | | | | | 4b. City. Town. | Month Augus or Location of De | t 22, | 199 | Yeer 7 1 of Death | 0:15pm |
| | | | <i>ı</i> . | | | | _ | | | | |
| 5. Social Sacurity Nu 226-22-93 | mbar 6. S | Avenue #14 ax 7. Age | in yrs. last b | | If Under 1 \ | | | Birth Day, Year) | | 9. Birthplaca (Country) Virgin | Stata or Foraign |
| Usual Residence of D | Dacedant | | | | | | | , | | | |
| | 10b. County | | 10c. City, To | | | | | | | | Side City Limits ☐ Yas 2 □ No |
| Maryland 10e. Streat end Numi | Montgome | ery | Gaithe | ersbur | | .4- | | 10- 00 | | | Jias ZLJNO |
| | | | 11 9 1 | | 10f. Zlp Co | | | | | What Country? | |
| +29 Christ 11. Marital Status | opher Av | renue Apt. | | 13 Wa | 2087 | 7 9 t of Hispanic Origin? | (Specify Ves or | The same of | | States e - American Ind | lian |
| 1 Never Marrie | d 2 ☐ Married | Armed Forces? | | If Y | as, specify | Cuban, Mexicen, Pu | arto Ricen, atc.) | 140- | | ck, Whita, atc. | ngur, |
| 3 Widowed 4 | | If Yas, Give Yeer or Detas: | | 1 | Yas 212 | No Specify: | | | Specify | White | |
| | 15. Dacedant's Ec | | 16 | e. Deceder | nt's Usuei O | ecupation fona during most of a | work in a | 16b. Kl | nd of Bu | usinass/industry | 4. |
| Elemantery/Second | | Coilege (1-4or 5 | | iifa. DO | NOT usa r | ona dunng most or v atired) | working | | NIH | | |
| 17. Father's Nama (F | First, Middla, Last) | | | | | 18. Mothar's N | leme (First, Mide | dla, Maidan | Sumem | 10) | |
| Ivory C. | Wells | | | | | Gertr | ude Gal | loway | | | |
| 19e. Informant's Nan | ne/Reletionship (| Type, Print) | 19 | b. Mailing | Addrass (S | traet and Number or | Rural Routa Nur | nbar, City o | r Town, | Steta, Zip Code |) |
| 23a. Part 1. Shtar tha | hack a disaasa, or com | D. Hibbo. plications that caused | NS tha daath. Do | Gai | Lthers | Deer Park subrg, MD dying, such es cerd | 20877 | y arrast, | | Appro | oximete |
| snock, or heart | | one ceuse on aach lin | | | | | | | | | vel Batwaan at and Death |
| disaasa or condition resulting in daath) | | . GLIOB | Lasto Due to (or as a | | ence of): | | | | | Mo | NHS |
| Sequantially list conditions and land | nadiata | b | Due to (or es e | e consaqua | nce of): | | | | | | |
| causa. Entar Undarly Causa (Disaase or in thet Initiated avants rasulting in daath) La | ying njury | c | Dua to (or es a | consequa | nce of): | | | | | | |
| resulting in General Es | | d | | | | | | | | | |
| Part il. Other signific | ant conditions of | ontributing to death bu | t not resulting | In the unde | arlving caus | a givan in Part I. | 23b. D | id tobacco | use cor | ntributa to the c | ause of death |
| | | | 4 | | | | | ☐ Yes 2 | | 3 Probably | |
| Atrial 1 | Fibrilla | yperlipi o tion | | | | | | as an autop informad? | osy | 24b. Were eur available complatie of death? | prior to on of ceusa |
| MIGRAIN | E HEAL | PACHES | | | | | 11 | Yas 21 | No | | 2 No |
| 25. Was cesa raferre axaminar? | 0.00 | Hospital: | | | -5 | Other | Death (Check on | | | | |
| 1 ☐ Yes 223 N 27. Mannar of Deeth | 0 | 28a. Data of Injur | v 28b. | Outpatient Tima of | 3□ DOA 28c. | 4 Li Nursing | 9 Homa 5 ☑ Ra 28d. Dascrit | | _ | ar (Specify) red | |
| 1.⊠Natural 2 ☐ Accidant | 5 Panding Invastigation | (Month, Day | Year) | Injury | М | Injury at Work? 1 Yes 2 No | | | , | | |
| 3 ☐ Sulcida 4 ☐ Homicide | 6 ☐ Could not be datarminad | 28a. Placa of Inju building, atc | ry - At homa, t . (Specify) | farm, straat | t, factory, of | ffice | | n (Straat en Town, Stata, | | er or Rural Rout | a Number, |
| 29a. Certifier 1 (Check only 2 one) | ☑ Cartifying Ph | yalcian: To the best of linar: On the basis of end manner stat | axaminetion e | ga, daath oo end/or Invas | ccurred at ti | ha tima, date end ple my opinion, deeth oc | ece, end dua to to | he causa(s) ne, date end | and ma | annar as stated. and dua to tha c | ausa(s) |
| 29b. Signatura and tit | tle of certifier | | | | 29c Li | censa number | | 29d, Dat | e signa | d (Month, Day, Y | /aerl |

D 31839

August 25, 1997

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The lew requires that the death cartificate be executed within 24 hours effer death.

To the Funeral Director: After this cartificate hes been signed by the attending physician end completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Christopher C.

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Be

Funeral Director

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Heelih and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, Tie Medical Examinal must be not find at once.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

State

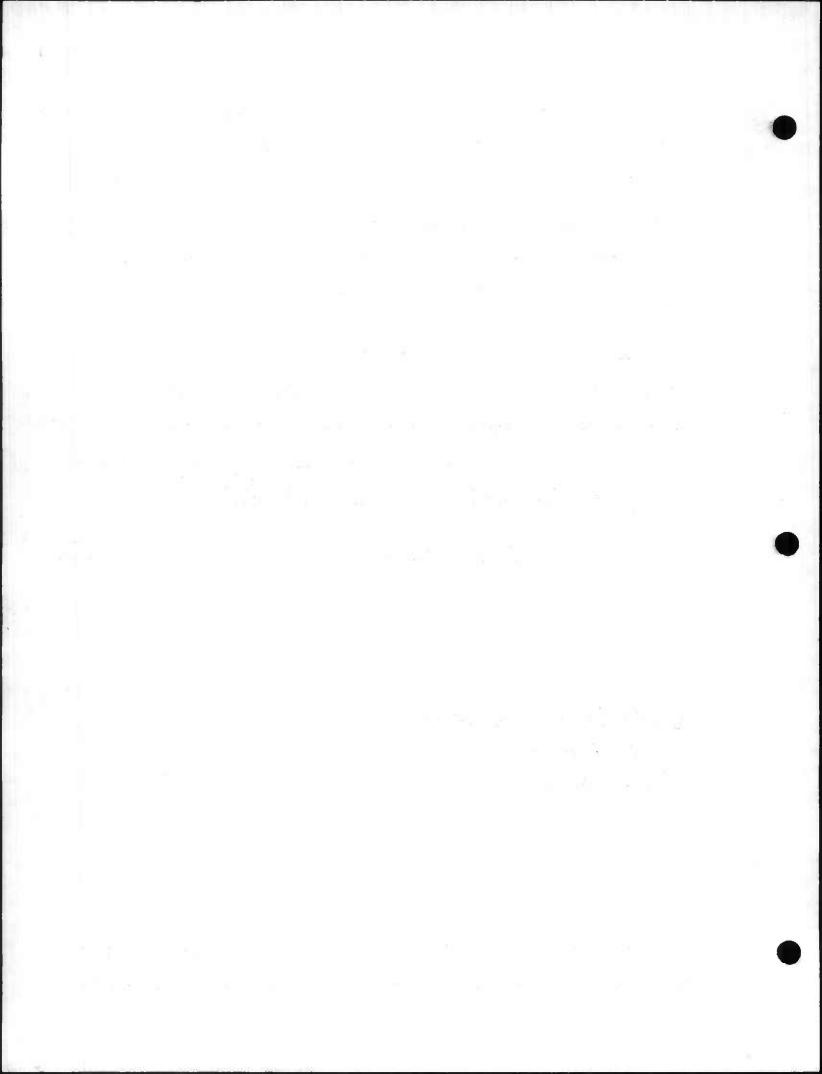
Registrar

M.D. 615 West Montgomery Avenue, Rockville, MD 20850 31. Date filad (Month,

30. Nema and addrass of person who completed causa of death (Itam 23a) (Type, Print)

Dunford,

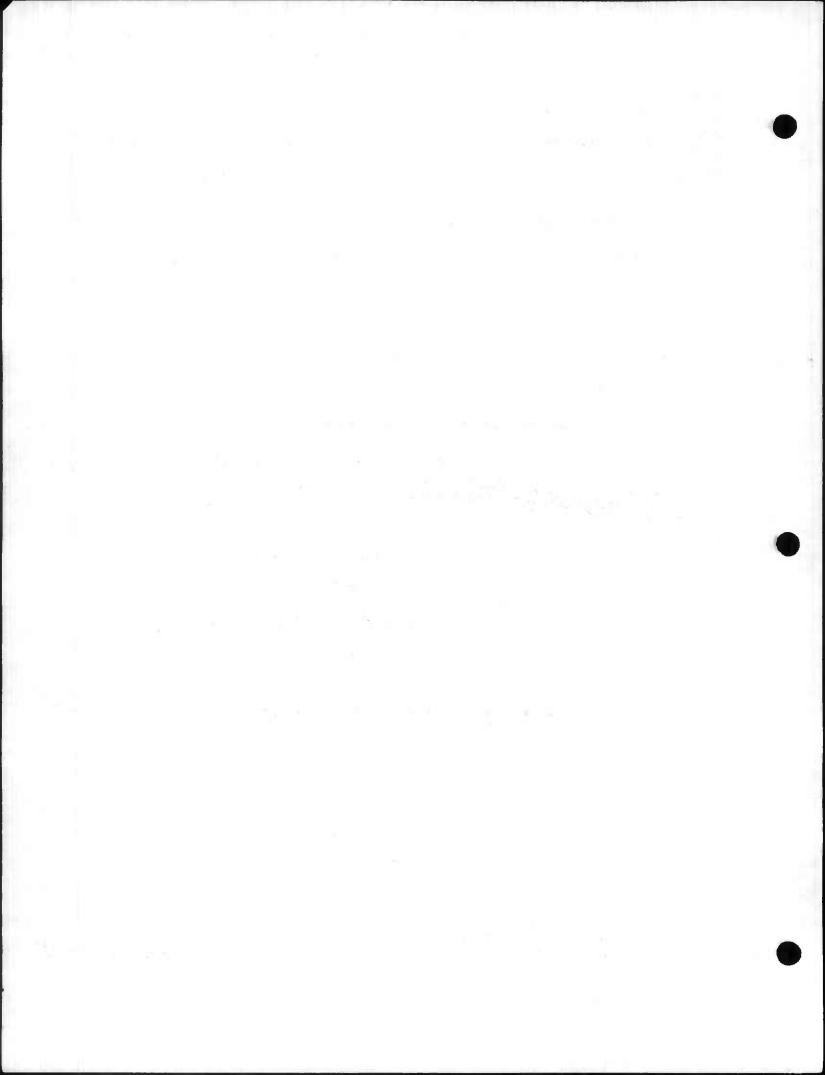
25



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 1 27 1 78

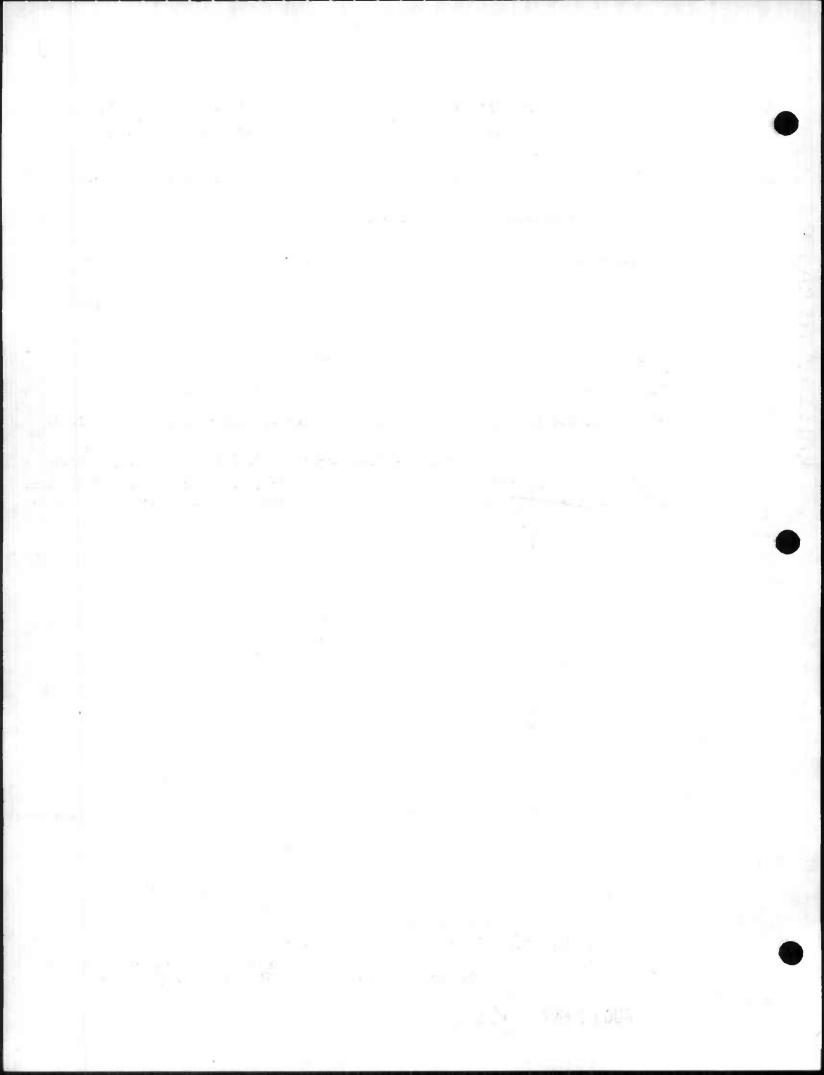
| | | Decedent's Neme (First, Middle | le (ast) | | Cen | ificate of | Death | 2. Dete of De | Reg. No. | | 3. Time of Deeth | |
|---|------------------|--|---|------------------------|-----------------------------|-----------------------------------|--|---------------------------------|----------------------|--------------|--|--|
| Physic | ian | Raymond A. Ja | | | Month Dey August 22, 199 | | Yeer | | | | | |
| /Med | | 4e. Fecility Neme (If not institution | | -1 | | 1 | 4b. City, Town, or Location of Deet | | | | 5:50 AM | |
| Exami | ner | Suburban Hosp | Title Control of the | / | | | | | | | | |
| | | 5. Sociel Security Number | | ge (In yrs. la | et hirthday) | If Under 1 Year | Bethesda | 9 Date of Bir | | gomer | 4 | |
| Funera Director | _ | 579-12-4436 | 6. Sex 7. A | 76 | Yrs. | Months Deys | | 8. Date of Bir (Month, De | y, Year) | | pleca (Stete or Foreign ntry) | |
| | | Usuel Residence of Decedent | | 70 | | | | Sept.2 | 4,1920 | Wash | ington, D.C | |
| /land | | 10a. Stete 10b. County | | 10c. City | Town or Loca | tion | | | | 1 | 10d. Inside City Limits | |
| Man Man | | | | | | | | | | | | |
| T 28a | | 10e. Street end Number | | | ver op. | 10f. Zip Code | | | 10g. Citizen of | Whet Cour | ntry? | |
| 3a o | | 14225 Grand P | re Road | | | 20906 | | | United | | | |
| d 21215-0020 filled within 72 hours effer death with the Maryland Hygiene. ther then "natural", or frems 23s or 28s-f show ent, the Medical Exprisher mant to notified a | | 11. Meritel Status | 12. Wes Decedent | t Ever In U,S | 5. 13. We | | Hispenic Origin? (Sp. | ecify Yes or No | | | can Indien, | |
| fter dea | | 1 ☐ Never Married 2 🕅 Marr | Armed Forces | | If Y | es, specify Cub | Hispenic Origin? (Spoan, Mexican, Puerto | Rican, etc.) | Ble | ck, White, | | |
| 21215-0020 d within 72 hours eff giene. Ir then "netureit, or | by | 3 ☐ Widowed 4 ☐ Divorced | If Yes Give | | 10 | Yes 2 No | o Specify: | | Specify: Black | | nak | |
| 2 ho | Be Completed I | 15. Deceden | 15. Decedent's Education (Specify only highest grede completed) [Give kind of work done during most of work] [Induction (Give kind of work done during most of work] [Induction (Give kind of work done during most of work] | | | | | | | lusiness/in | | |
| 215 Fig. 10 | | (Specify only higher Elementery/Secondary (0-12) | st grede completed) College (1-4or | E.) | (Give kii life. DC | nd of work done NOT use retire | during most of work ed) | ing | | | | |
| 212 d with piene. | | 12TH | College (1-40) | 5+) | Clerk | | | | D.C. (| Gover | nment | |
| nd 2 | 9 | 17. Fether's Neme (First, Middle, | Last) | | | | 18. Mother's Name | e (First, Middle, | | | imene | |
| Tar | To B | Alonzo Jackson | | | | | Marie F | Richard | son | | | |
| Maryland of 2 should be file the end Mentei Hy ?? Is marked other traumatic event | 1 | 19a. Informent's Neme/Relations | hlp (Type, Print) | | 19b. Mailing | Address (Stree | t and Number or Run | | | , Stete, Zip | Code) | |
| Mod 2 | | Geraldine J. P: | inkett, sist | er | 14225 | Grand I | Pre Road | #103 | Silver (| Sarin | g,MD 20906 | |
| Baltimore, Misperser, Pages 1 and 2. Department of Health el Important: if Item 27 is any injury or other trau once. | | 20a. Method of Disposition | | 20b. Pla | ce of Disposit | ion (Name of tory or other ple | re Road, | Dete | 20c. Location | | | |
| anto y or It | | 1 ☐ Burial 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (S) | | 3 | - | cremat | | /25/07 | D - 1 | | | |
| injury in B | | 21. Signeture of Confal Servica | ** | One | | lame end Addre | | 0/23/9/ | Deltsvi | tire, | Maryland | |
| B E B B B B B B B B B B B B B B B B B B | | T. | 01 / | ٠,, | Mc | Guire Fu | uneral Ser | vice, | Inc. | | | |
| NA SAN | | Benry. | 0.70 | | 740 | 0 Georg | gia Ave. N | I.W., Wa | ashingto | on, D | | |
| 0_ | | and Enter the disease, or shook, or heart feiture. List | only one cause on each i | id the death. line. | Do not enter | the mode of dy | ing, such es cardiac | or respiretory e | rrest, | 1 | Approximete Intervel Between | |
| Physician /Medicai | | Immediate Cours (Final | | | -+ | _ | | | | 1 | Onset end Death | |
| Examiner | | Immediete Ceuse (Finel disease or condition resulting in death) | θ | as | sual | m (| rlunom | a | | | | |
| | 1 | reading in deathy | | Due to (or | es e conseque | nce of): | | | | | | |
| 3 8 2 | Ę | | a b. | | der | rentea | | | | | | |
| Para and | Examiner | Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cuse, (Disease or injury Cuse, (Disease or injury Cuse, (Disease or injury) | | | | | | | | | | |
| be e bunician | <u>e</u> | | | | | | | | | | | |
| 68760, FM. 68760, FM. fificate be executed applysician end es the buriel-transit | edical | resulting in deeth) Lest | | Due to (or | as a conseque | nce of): | | | | | | |
| | Me | | L a | | - 5 | 0 | | | | | | |
| ords, P.O. Box requires that the death cer seen signed by the ettendir hould be deteched for use | Physician/M | | -c:\!\! | | | | | | | 1 | | |
|) % a a a a a | ysi | Pert II. Other significant condition | | out not resui | ting in the und | erlylng cause gi | iven in Pert I. | 23b. Did | tobecco use co | entribute to | the ceuse of death? | |
| de by de by | 윤 | sessy se | condans | als | we, | with | MRS4 | 10 | Yes 2 No | 3 Prol | bably Junknown | |
| Cords, | d by | | | | | | | 0.4- 141 | discovered and | T 245 W | ere eutopsy findings | |
| Cor Cor required | Completed | | | | | | | 24a. Wes | en eutopsy ormed? | ev | elleble prior to empletion of cause | |
| 7 0 × 0 × 0 | du | | | | | | | 1 7 | | | deeth? | |
| _ F # a | S | | | | | | | 10 | Yes 20 No | 10 | yes 2□ No | |
| of Vital I Physicien: The this certificate and director, page | Be | 25. Wes case referred to medical exeminer? | | e | | | 26. Plece of Deatl | h (Check only o | one) | | | |
| Of V Physic this ce | 2 | 1 Ves 2 No | Hospitel: 1. Inpati | ient 2 E | R/Outpetient | 3□ DOA OH | her: 4 Nursing Ho | me 5 Resid | denca 6 Oth | ner (Specify | y) | |
| Affect th | Certification: 7 | applications are a second to the second to t | | | | | | | | | | |
| | | 1 Naturel 5 Pending (Month, Day Year) 2 Accident investigation (Month, Day Year) | | | | | | | | | | |
| Division of the management of the characters of | tif | 3 ☐ Sulcide 6 ☐ Could r 4 ☐ Homicide determ | ned Zoe. Flede of In | jury - At hon | ne, farm, street | , factory, office | 0 | 28f. Location (3 City or Tox | Street and Numi | ber or Rure | al Route Number, | |
| S S S S S S S S S S S S S S S S S S S | Ce | | bollottig; c | io. (opoony) | | | | / | | | | |
| - Pour Pour Pour Pour Pour Pour Pour Pour | cai | 29a. Certifier 1 Certifyin | g Physician: To the best | of my know | ledge, deeth o | ocurred at the ti | ime, dete end place, | and due to the | cause(s) end m | anner es si | lated. | |
| DIVI DIVI To the Hospital or At within 24 hours after To the Funeral Direc | edical | (Check only one) 2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated. | | | | | | | | | | |
| vith To t | Σ | 29b. Signature and title of ceriffer 29c. License number | | | | | | | 29d. Dete signe | d (Month, | Dey, Year) | |
| 63 3 | | Yohatx | Zhelle | N N | D | Do. | 358/ | 1 | Markent | - 27 | 1997 | |
| | | 30. Name and address of person | who completed cause of | deeth (Item : | 23e) (Type, Pri | | | C | Ingro | | ,,,, | |
| | | Elliot R. Gold | | | | | .:Betheed= | MD 208 | 814 | | | |
| St | ate | 31. Dete filed (Month Dig 22) | 1007 32. Regist | | Bor-Rang | | , Joe Criebac | 71111 200 | | | | |
| Regist | | AUG 2 | 1331 | my knew (c | man- Mark | 4-6 | | | | | | |



| | | | | State of | Marylan | | artment of <i>tificate o</i> | | d Mental Hy | rgiene D Reg. No. | 1 61113 | | |
|-------------------------|--|--|---|------------------------------------|---|---|--|--|---|---|--|--|--|
| 4 | Physic | | 1. Decedant's Nama (First, Middle, Last) Panayota Nora Kallis | | | | | | | 2. Date of Death Month AUGUST Day 15 Year 4-15 Am | | | |
| | /Medi Examii | | 4a. Facility Name (If not institution, o | | | | | 4b. City, Town, | or Location of Deat | h 4c County | | | |
| | Funeral Director | | 214-44-3800 | Sax 7. 1 □ M 2 ▼ F | | | | ar If Under 24 I | Ain. (Month, Da | th sy, Year) 14 1918 | Birthplaca (State or Foraign Country) Greece | | |
| laryland | show | - | Usual Rasidance of Dacedent 10a. Stata 10b. County MD Anne A | Arundel | 10c. City | y, Town or Lo | cation verna P | 1- | | | 10d. Inside City Limits 1 ☐ Yas 2€No | | |
| death with the Maryland | or 28a- | Director | 10e. Straat and Number | Tebiliti | | 56 | 10f. Zip Code | | | 10g. Citizen of W | | | |
| T pet | al', or items 23a or 28a-f show Examiner must be notified at | by Funeral | 43 Sequoia Road 11. Marital Status 1□ Navar Married 2□ Marriad 3℃Widowad 4□ Divorced | Armed Force 1 ☐ Yas 2 If Yas, Giva | 1 ☐ Yas 2 ☒ No | | | 1146 ° f Hispanic Origin? uban, Mexican, Pu o Specify: | ? (Specify Yes or No uerto Rican, atc.) | | States - Amarican Indian, c, Whita, atc. White | | |
| Maryland 21215-0020 | of KIKID-COCKO | Completed | 15. Decedant's E (Spacify only highast g Elementery/Secondary (0-12) | (Giva | lant's Usuel Occ kind of work don DO NOT usa rati | na during most of red) | 16b. Kind of Businass/Industry Home | | | | | | |
| aryland | marked other than | To Be C | 17. Father's Nama (First, Middla, Les Thomas Sofos 19a. Informent's Name/Ralationship | | | 19b. Mailin | | 18. Mothar's | Nama (First, Middla Helen Rou r Rural Routa Numb | , Ma <i>idan Suma</i> ma kis | n) | | |
| | = 0 | | Nicholas J. Kal 20a. Method of Disposition OBurial 2 □ Cremation 31 | llis (Son | 20b. P | 90 lace of Disposamatary, crem | Cathedr sition (Nama of natory or other p | al Stree | t Annapo | lis, Mar 20c. Location - C | yland 21401 City or Town, Stata | | |
| Baltimore, | Important: any injury once. | | St. Demetrius Cemetery 8/18/97 Annapolis, Maryland 21. Signeffure of Funeral Service Licenses 22. Nama and Addrass of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 | | | | | | | | | | |
| Exa | chysician and the burel-transit the burel-transit | Immediate Cause (Final death) By the Conditions of the Course (Final death) By the Course (Final deat | | | | | | | | | | | |
| . Box 6 | has been signed by the attending r ge 2 should be deteched for use as | Physician/Medicai | rasulting in death) Last Dua to (or as a consequence of): | | | | | | | | | | |
| S, P.O | | Certification: To Be Completed by | | | | | | | | | | | |
| Record | | | | | | perfo | 24a. Was an eutopsy performed? 24b. Were eutopsy fin available prior to completion of car of death? 1 \(\text{Yes} \) 2 \(\text{SINo} \) 1 \(\text{Yes} \) 2 \(\text{SINo} \) | | | | | | |
| of Vita Physician: | fler this certific ineral director, | | 25. Was casa rafarred to medical axaminer? 1 Vas 2 No 27. Mennar of Deeth 1 Natural 5 Pending Invastigation | Hospital: 1 ☐ Inpa | 100 | ER/Outpatient 28b, Tima of Injury | 28c. In | thar: 4□ Nursin | Death (Check only of g Homa 5 Rasic 28d. Dascribe | | r (Specify) | | |
| 5 6 4 | i b | | 3 Suicida 6 Could not to datermined | Injury - At ho etc. (Specify | me, ferm, stra | at, factory, offic | 9 | | ocation (Streat and Number or Rural Routa Number, City or Town, Stata) | | | | |
| To the Hospital | To the Funeral Dir completely filled in | Medicai | 29a. Cartifier (Check only one) 29b. Signatura and titla of artifiar | nysician: To the bes | of axaminet | viedga, deeth ion and/or Invi | astigetion, in my | time, deta and pla opinion, death of hisa number | ccurred at tha tima, | ee ceusa(s) and mannar as steted. a, data and place, and dua to the cause(s) 29d. Data signed (Month, Day, Year) AUGUST 15 1997 | | | |
| | | | 30. Nama and address of person who | ITAL,30 | daath (Itam | 23a) (Typa, F | | | | | NORTH | | |
| | Sta Registr | | 31. Data filad (Month, Day, Year) AUG 1 9 19 | 32. Regis | strar's Signat | | | | | | | | |

DHMH 16 Rev 6/95

KALLIS

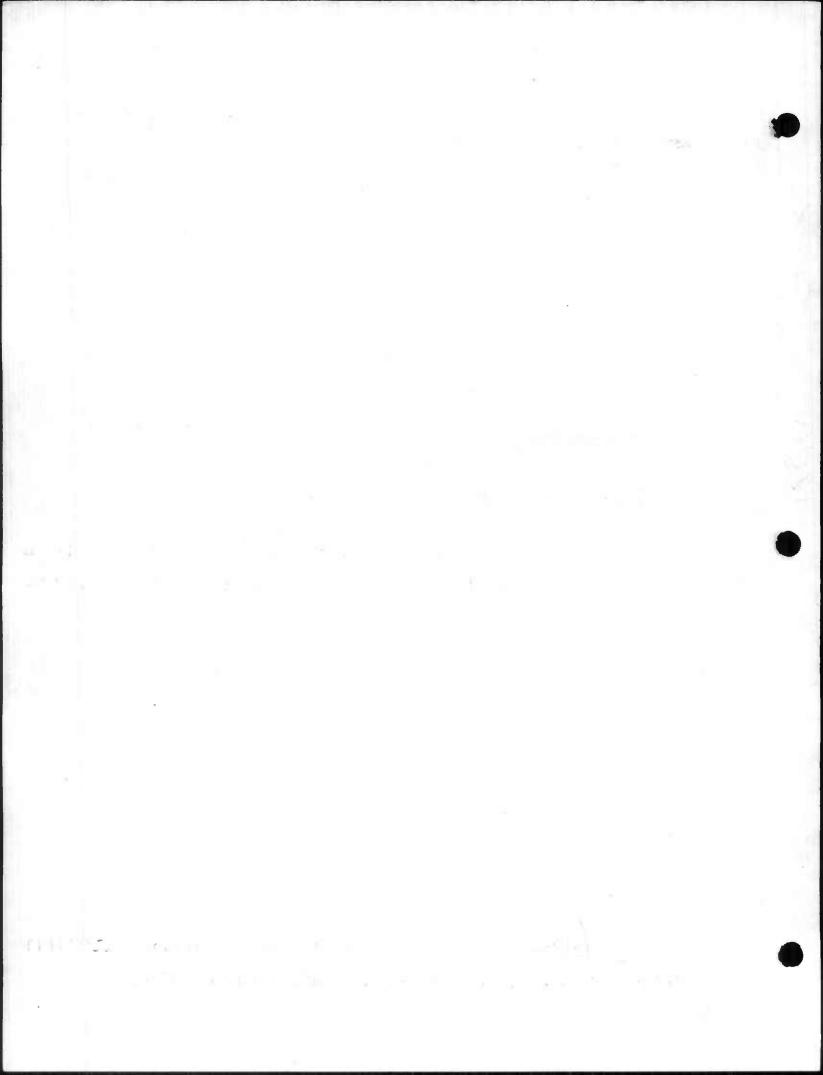


| | | | | State of Ma | aryland | | | f Health a of Death | and Mo | | iene 9 | 1 2 | 7180 | |
|------------|--|---|---|---|---|---|---|--------------------------------------|---|---|---|---|----------------------------|--|
| | Physici /Medic | | THEO KOZIII | | | | | | | Month Day Year | | | 3. Time of Death 7:13 Am | |
| | Examir | | 4a. Fecility Neme (if not institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Death | | | | | | | | | | | |
| | Funeral Director | | 091 80 3168 | | 7. Aga (In yrs. last birthdey) | | | Berli aar If Under | | 8. Dete of Birth (Month, Day, 10/13/ | Worceste (, Year) 9. Birt Co 1944 Russ | | rthplace (State or Foreign | |
| | and | | Usuel Rasidence of Decedent 10a. Stele 10b. County 10c. City, Town or Location | | | | | | | | 10 | Od. Inside City Limits | | |
| | Mary H sho | tor | MD Anne Art | ındel | Ann | apolis | | | | | | | 1 ☐ Yes 2 No | |
| | or 28s |)irec | 10e. Street end Number | | <u> </u> | | 10f. Zip Cod | de | | | 0g. Citizen of | What Coun | try? | |
| | ath w | rai | 2042 Puritan Terr | | | | 2140 | | | | Russia | | | |
| 21215-0020 | 2 should be filed within 72 hours after death with the Manyand and Mental Hyglens. Is marked other than "natural", or items 23s or 28s-f show aumatic avant, the Medical Expansion mast be notified at | by Funeral Director | 11. Meritel Stetus 1 Navar Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent E Armed Forcas? 1 Yes 2 N If Yes, Giva Year or Detes: | | lt. | /as Decedent Yes, specify (☐ Yes 2 ☑ | gin? (Spec i, Puarto R | pecify Yes or No- o Rican, atc.) 14. Race - American Indi Black, White, atc. Specify: White | | | ntc. | | |
| 5-0 | 72 ho | pete | 15. Decedent's Ed | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Buainess/Industrial | | | | | | lustry | | | |
| 121 | vithin na. han " | Completed | Elamentery/Secondery (0-12) College (1-4or 5+) | | | | | | | Music/Entertainment | | | | |
| Maryland 2 | should be filed withing Mental Hygiena. marked other than matte avant, the Mental Ment | To Be Co | 17. Father's Neme (First, Middle, Last) Mark Zielbervarg | | | | | 18. Motha | | e (First, Middle, Meiden Surnema) Kozina | | | | |
| lary | d 2 should th and Mer 7 is marke traumatic | - | 19e. Informant's Neme/Reletionship (7 | Type, Print) | | | | reet and Numbe | | | | | Code) | |
| | | | Nina Kozin (wife) | | act Di | | | n Terra | ice/Ai | _ | | | | |
| Baltlmore, | S 2 T | | 20e. Method of Disposition 1 ☐ Burlal 2 ☐ Cremetion 3 ☐ | | | | etory or other | | | | 20c. Location | | | |
| Ittl | permit. Page Department of Important: If any injury or once. | | 4 ☐ Donetlon 5 ☐ Other (Specify 21. Signeture of Fungfal Service Light | | Met | ropolitan Crematory 8 | | | | /18 | Atexai | Alexandria VA | | |
| Ba | Depar Impor any ir | | NOU WILLIAM | NIL - | 0 ^ | Ac | vent F | uneral | & Cre | emation | Servi | ces | | |
| | Physician /Medical Examiner | Immediata Ceuse (Finel disease or condition rasulting in deeth) a. ### Prinzry Watrialor f. 5r. //x** Due to (or as a consequence of): Interv. Onser | | | | | | | | | Approximata Interval Between Onser and Death 3 day 5 | | |
| | dansit | Examiner | b. Due to (or es a consequence of): | | | | | | | | | | | |
| 0, | e exec lan an urial-tr | | Sequentially list conditions, if any, leeding to immediata cause. Enter Underlying Cause (Disease or Injury | 200 10 (01 | | | | | | | | | | |
| Box 68760, | death certificate be executed attending physician and ad for use as the burial-transit | Physician/Medical | that initiated events resulting in deeth) Last | ence of): | ce of): | | | | | | | | | |
| | death e atte | sicia | Pert II. Other significant conditions co | | 23b. Did tobacco uss contributs to the causs of death? | | | | | | | | | |
| ls, P.0 | requires that the de been signed by the a hould be detached i | by Phy | | | 1 Yes 2 No 3 Probably 4 Unknown | | | | | | | | | |
| Records, | aw 2 s | Completed | | | | 24a. Wes an autopsy performed? 24b. Were autopsy thidings available prior to completion of cause of death? | | | llable prior to | | | | | |
| alF | | | | | | | | | | 1 🗆 Yı | 18 2 1No | 10 | Yas 20 No | |
| Vital | | o Be | 25. Wes case referred to medical examiner? 1 ☐ Yas 2 ☐ No | Hospital: | 1 2□E | B/Outpetlent | 3 DOA | Other: | Place of Death (Check only one) ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | | | | | |
| ion of | a fee | ation: T | 27. Menner of Death 1 Naturel 5 Panding 2 Accident invastigation | 28a. Date of injury (Month, Dey | Injury 28b. Time of 28c. Injury at | | | | 21 | | ibe how injury occurred | | | |
| Division | | Certification: | 3 Suicide 4 Homicide 6 Could not be determined 28a. Plece of Injury - At homa, tarm, street, tectory, office building, etc. (Specify) | | | | | | | | 281. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | Hospital or 24 hours afte Funeral Dir ately filled in | edicai | 29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exam | raician: To the best of iner: On the basis of end menner stet | axaminetic | ledga, death on end/or invi | occurred at the | e time, dete end ny opinion, daat | d piece, er th occurre | nd due to tha cod et the time, d | use(s) and mate end plece | nanner as st | eted. the ceusa(s) | |
| | To the within 2 To the comple | Me | 29b. Signeture and titla of certifier | Old Mellier ster | | | 29c. Lic | ense number | | 2 | 9d. Dete sign | ed (Month, I | Day, Year) | |
| | ->-0 | | oh- | ille | | | 44 | 4283 | | 8/14/97 (2 MD 21811 | | | | |
| | | | 30. Name and address of person who can bert Durit | complated cause of de | eth (Item 2 | 23e) (Type, F | Print) | 3 | ·/ l. | , h | 0 | 218 | 7// | |
| | Sta Registr | | 31. Date filed (Month, Day, Year) ALIG 2.1 10 | 32. Registra | r's Signatu | ire | 1.00 | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 27 18 1

| | | | | | | Cei | tificate | of L | Death | | | Reg. No. | | | |
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| /Med Exam | | ANNA 4a. Facility Name (If not ins | | ERINE | KN(| JX | | 48 | o. City, Tow | | AUG. | 23,19 | nty of Deeth | 4:(|)5 AM |
| LAGII | mici | 8796 CUMM | | | | | | | | гтма | | | ALBO | ר | |
| Funera | al | 5. Sociei Security Number | 6. Se | x | 7. Age (In yrs | . last birthdey) | If Under 1 Months | Yeer Deys | If Under 2 Hours | | Dete of Birt (Month, De | | | | tete or Foreign |
| Directo | or | 215-20-145 | 1 | M SYCOXE | 91 | Yrs. | INIOIRIIS | Doys | 110013 | J | AN. 27 | ,1906 | RUS | SSI | A . |
| pue *- | | Usual Residence of Deced | lent County | | 10c. C | ity, Town or Lo | cation | | | | | | 1 | Od Inei | de City Limits |
| ath with the Maryler 23a or 28a-f show | 5 | MD T | ALBOT | 1 | | WITTM | IAN | | | | | | 1 | | ∳es 2 No |
| 1 the | Je C | 10e. Street end Number | | | | | 10f. Zip C | ode | | | | 10g. Citizen o | of Whet Cour | ntry? | |
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| after deal or flems | Funeral Director | 11. Meritei Stetus | | 12. Wes Dece Armed For | dent Ever in U | J,S. 13. V | Ves Decede Yes, specif | nt of His | panic Origi | in? (Speci | fy Yes or No | - 14. F | lace - Americ | | en, |
| | þ | 1 Never Merried 3 | | 1 ☐ Yes If Yes, Giv Year or De | 2 X No | | ☐ Yes 2 | | Specify: | | 0011, 010.) | Spe | | VHI | re |
| 72 ho | Completed | 15. De | ecedent's Edu highest grade | cation | | 16a. Deced | ent's Usuel kind of work | Occupa | llon | of working | | 18b. Kind of | Business/In- | dustry | |
| within ene. | npie | Elementery/Secondery (| | College (1 | -4or 5+) | life. L | OO NOT use | retired) | ung most | or working | ′ | | | | |
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| s 1 and if Health item 27 other tr | | 20e. Method of Disposition | | | 20b. | Plece of Dispo- cemetery, cren | sition (Neme | of | | | Dete | 20c. Locatio | | - | te |
| Pages sent of I nt: If ite | | 1 N Burial 2 ☐ Crem 4 ☐ Donetion 5 ☐ Ot | | temovel from S | State | RING H | | | * | -8 Y | 26 | EASTO | N. MI | | |
| pemit. Pages 1 and 2 Department of Health 1 Important: If Item 27 is any injury or other tra | | 21. Signeture of Funerei S | | 90 _ | W | 22 | Neme end | Address | of Fecility | | l | NEWNA | | | T HON |
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| Physiciar /Medica Examine | l r | Immediate Causa (Final disease or condition resulting in deeth) | 6 | A7, | | C/CV3TC | | / de | DVAJ | 10/0 | - dis | 03/2 | | | |
| icate be executed physician and s the bunel-transit | Examiner | Sequentially list conditions if eny, leading to immediate | |), | Due to (| or es e conseq | uence of): | | | | | | | | |
| cate be exacu physician and the bunel-trai | edical | cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last | ۰ | ÷. ———— | Due to (d | or es e consequ | uence of): | | | | | | - | | |
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| att att | Physician/M | D-40 000-1-100 | 41-4 | | | | | | | | | | 1 | | |
| the the | hysi | Pert fl. Other significant co | | , | | y | derlying cau | se give | n in Pert I. | | | | | | use of death? |
| | by P | (NO bro | VAIL | 12 | Acce | don't | | | | | 10 | Yes 2 No | 3 Proi | Dabiy | 4 🖺 Unknow |
| requir been s should | Completed t | | | | | | | | | | 24a. Was perlo | en autopsy med? | av co | ailable p | psy findings rior to n of cause |
| The law ate has b page 2 s | E O | | | | | | | | | | 101 | es 2 No | | | 2 No |
| | BeC | 25. Wes case referred to m | nedical | | | | | | 26. Plece o | of Deeth / | Check only o | | 1 | 7 165 | 20140 |
| 0 0 | To | exeminer? 1 Yes 2 No | Н | lospitel: | patient 2 | ER/Outpetien | 3□ DOA | Other | | | | lence 6 🗆 C | other (Specif | y) | |
| | | 27. Manner of Death 1 ☑ Neturel 5 ☐ F | Pending | 28e. Dete o | f Injury n, Dey Year) | 28b. Time of tnjury | 280 | . Injury Work | et · | 28 | d. Describe h | ow injury occ | urred | | |
| Attanding or death. actor: Afte by the fune | catic | 2 Accident | nvestigation Could not be | - 107 | | | М | | es 2 N | 0 | | | | | |
| | Certification: | | determined | 28e. Plece o | of Injury - At h g, etc. (Speci | ome, ferm, stre fy) | et, fectory, o | office | | 28: | f. Location (S City or Tox | Street and Nu m, Stete) | mber or Rura | / Route | Number, |
| To the Hospital o within 24 hours at To the Funeral Di completely filled is | edical | 29a. Certifier 1 Ce (Check only one) 2 Me | ertifying Phys edicat Examin | lician: To the ter: On the basend menn | sis of examina | wiedge, deeth ition end/or Inv | occurred et estigetion, Ir | the time my opi | , dete end nion, deeth | plece, end | d due to the d | ceuse(s) end dete end piec | menner as si a, and due to | tated. | 180(S) |
| within 7 To the comple | Me | 29b. Signature and title of o | pertifier | 20 | > _ | . / | 29c. l | icense | number | | | 29d. Dete sig | ned (Month, | Day, Ya | er) |
| . , , , | | who | _ | PI | / | 1 | 7 | 77 | 146 | | | 8/ | 25k | 7 | |
| | | 9 | rson who co | mpiesed gause | of death (Iter | n 25a) (Type, F | rint) | | 10 | 0 | | 0/ | // | /_ | |
| | - (| , 1 . / | -/ 1 | 9/ / | 11 | | - | - | 7 | -/ | | | | | / |
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| ysiciar | - | 1. Decedent's Nen | rence | | Hark | ins | Ked | gley | | | | 2. Date of D Month Aug. | Dey | Yaer . 997 | | of Deeth |
| Medica amine | _ | 4a. Fecility Neme | | | | | | <u> </u> | | 4b. City, T | | ocation of Dea | | nty of Deeth | 2.1 | OJ F. |
| | | Fal | lston | Gene | eral : | Hosp | ital | | | Fall | sto | n | На | rford | 1 | |
| eral | П | 5. Social Sacurity | | 6. Sax 1 ☐ M | | Aga (In yrs | . last birthday) | If Und Months | er 1 Year s Deys | If Unde Hours | r 24 Hrs. Min. | 8. Date of B (Month, D | irth lay, Year) | 9. Birth | olece (Ster | te or Foreign |
| otor . | | 212-38- | | 1 LJ M | * | 91 | Yrs. | | | | | 1/2/ | | Mary | | |
| | - | Usuel Residence of 10a, Stete | of Decadent 10b. County | | | 100.0 | the Town or L | nantian | | | | | | | 04 1-11- | 02-11-7 |
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| 1 | | 10e. Street and Nu | | | | | | 10f. Z | Ip Coda | | | | 10g. Citizen | of Whet Cour | ntry? | |
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| 1 | Funeral Director | 11. Marital Status | | 12. | Nes Deceda Armed Force | nt Evar in I 😭 | U,S. 13. | Was Dec If Yas, sp | edent of hecify Cub | dispenic Or en, Mexica | rigin? (Spo n, Puarto | ecify Yes or N Rican, etc.) | o- 14. F | Race - Amario Bieck, White, | | |
| 0 | F | 1 Never Man | | | l □ Yes 2 d f Yas, Giva | No | | | 2 X) No | | | | | city: | | |
| 7 | O D | 3 Widowed | 4 ☐ Divorced | d , | Yaar or Data | s: | | | | | | | | Wh | ite | |
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| á | 9 | 17. Fether's Neme | | | 1 | | | | | | | e (First, Middl | e, Meiden Sun | neme) | | |
| F | 2 | Georg | e Edi | ward | Hark | ıns | - | | | Vi | ola | | Fam | ous | | |
| | | 19e. Informant's N | lame/Reletions | ship (Type, i | Print) | | 19b. Meili | ing Addre | ss (Street | and Numb | er or Rura | al Route Num | ber, City or To | wn, Stete, Zip | Code) | 1084 |
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| | | 21. Signature of F | uneral Service | Licensee | -355.00 | | 2: | 2. Neme e | end Addre | ss of Facil | ity | | | | | |
| | | 150 | | 11 | His | 1 | | Jar | rett | svil | le, | Md. | 21084 | | O. I | |
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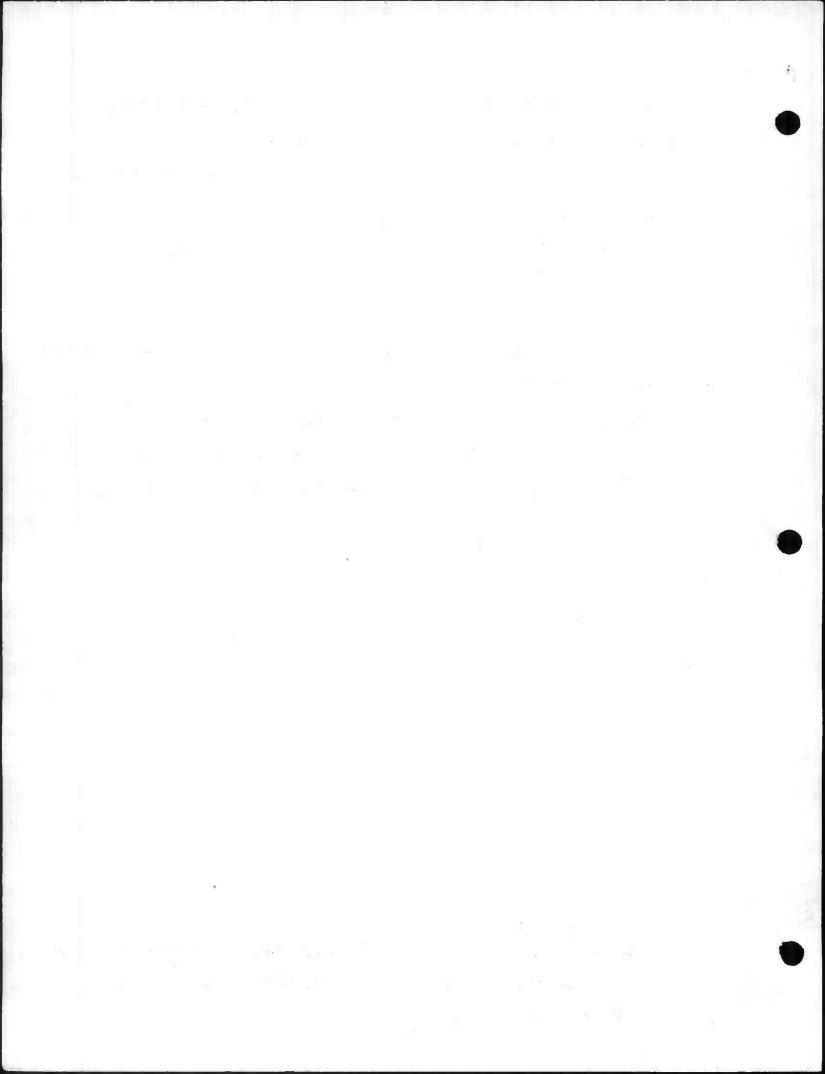
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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| | /Medi | | MARJORIE FE | ATHERSTUN K | ELLY | | | | Acepust | - 22 10 | 197 | 4 20 AM |
| | Exami | ner | 4e. Fecility Neme (If not instituti | the second and the second | ber) | ٠ | | 4b. City, Town, or | | 4c. County | of Deeth | |
| L | | | Union Memoria | | | | - | Baltimo | | | | |
| | Funeral Director | | 5. Social Security Number 223–32–4996 Usuel Residence of Decedent | 6. Sex 7. 1 □ M 2 🔀 F | . Age (In yrs. 67 | lest birthday Yrs. | Months Days | | | y, Yeer) 1, 1930 | Count | ece (Stete or Foreign try) inia |
| | land w | | 10e. Stete 10b. Count | y | 10c. Cit | y, Town or L | ocation | | | | 10 | Od. Inside City Limits |
| | Mary Lish thed | to | Maryland Har | ford | E | el Air | r | | | | | 1⊠ Yes 2□No |
| | r 28c | Director | 10e. Street end Number | | | | 10f. Zip Code | | | 10g. Citizen of | Whet Count | try? |
| | th wit | a D | 707 Idlewild | Road | | | 2101 | .4 | | USA | | |
| 21215-0020 | d within 72 hours after death with the Maryland jiene, it than "natural", or Itema 23a or 28a-f show the Medical Examiner must be incitited at | by Funeral | 11. Maritel Stetus 1 □ Never Married 2€□ Maa 3 □ Widowed 4 □ Divorce | If Yes Give | es? ⊠ No | ,S. 13. | Was Decadent of If Yes, specify Cub 1 ☐ Yes 2 ☑ No | Hispenic Origin? (S an, Mexican, Puerl Specify: | pecify Yes or No o Rican, etc.) | 14. Rad Ble Specif | ce - America ck, White, e y: Whi | etc. |
| 5-0 | 72 ho | ted | 15. Decede | ent's Education est grede completed) | | 16e. Dece | dent's Usuel Occu | pation | tina | 16b. Kind of B | usiness/ind | ustry |
| 121 | within ene. | Completed | Elementery/Secondery (0-12) | | lor 5+) | | | during most of wor | King | Homi | 4-7 | Madiani |
| | ygier ygier if, fr | ပို | | 4 | | Reg1: | stered Nu | T | | - | | Medical |
| Maryland | should be filed valued white the state of th | Be C | 17. Fether's Neme (First, Middle Robert Sterl | | stun | | | 18. Mother's Ner | ne <i>(First, Middl</i> e, Du Eanes | | ne) | |
| N N | s 1 and 2 should f Health and Men frem 27 Is marke other traumatic | 1º | 19e. Informent's Name/Relation | | | 19b Mail | ing Address (Stree | t end Number or Ru | rel Route Numbe | er City or Town | State Zin | Code |
| X | end 2 salth er n 27 ls | | James Kelly/Hu | | | | | Road, Be | | | | 3000) |
| re, | of Health of Health fitem 27 r other tr | | 20e. Method of Disposition | | | lece of Disp | osition (Neme of metory or other ple | T | Dete | 20c. Location - | City or Tov | vn, Stete |
| Ë | Pages nent of nt: If its iry or o | | Burlel 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (- | | ete Wes | thamp | ton Mem. | Park | 8-25-97 | Richmo | nd, V | A |
| Baltimore, | permit. Pages 1 e Department of He Important: If item any injury or othe | | 21. Signature of Theral Service | a Licansee | / | 1 | | McComas | | | | |
| | 1000 | | 23a. Pert1. Ent r the diseese, o | or complications wat cau | sed the deet | n. Do not en | 1317 Cok∈ ter the mode of dvi | sbury Ro | ad, Abir | gdon, M | | Approximete |
| | Physician | | 23a. Pert1. Ent in the disease, of shock, or heart feilure. Lis | st only one coust on eed | h line. | | | | | | | Intervel Between Onset end Deeth |
| | /Medical | | Immediete Ceuse (Finel disease or condition | IR. | PARIS | ato | , 10 | iluno | | | | 2101.4. |
| | Examiner | | resulting in deeth) | e | Due to (o | r es e conse | evence of): | mure | | | | - quous |
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| | The law requires that the death certificete be executed at has been signed by the ettending physician and page 2 should be deteched for use as the burist-transit | Medical Examiner | Sequentielly list conditions, | 6. | Due to (o | r es e conse | | | CPPL | | | 1 110 |
| 60, | clan d | al E | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury | | | | | | | | | |
| 68760, | physi the t | dice | thet initieted events resulting in deeth) Lest | | Due to (or | es e conse | quence of): | | | | | |
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| | that ned b | by P | Lypertens | · m | | _ | | | 1 - | Yes 2 No | 3 Prob | ably 4 Unknown |
| ğ | v requires that been signed t should be dat | | 0. | | | | | | | en eutopsy | | re eutopsy findings lieble prior to |
| 000 | aw re | Completed | | | | | | | репо | rmed? | com | pletion of cause leath? |
| ď | The lay | mo | | | | | | | 101 | es 2 No | 10 | Yes 22 No |
| ta | | Bec | 25. Wes case referred to medica | al | | | | 26. Plece of Dec | eth (Check only o | - (| 1 | |
| > | Physician: r this certific real director, | ToE | exeminer? 1 ☐ Yes 2 ☐ No | Hospitel: | atient 2 🗆 | ER/Outpetie | nt 3 DOA Ott | 200 | ome 5□Resid | | er (Specify) |) |
| 0 0 | ng Phys ter this neral di | | 27. Menner of Deeth 1 DNeturel 5 ☐ Pendi | 28e. Dete of I | njury Dey Year) | 28b. Time o | f 28c. Inju Wo | ry et rk? | 28d. Describe h | ow injury occur | red | |
| Sio | Attending or death. ector: After by the fune | catl | 2 Accident Invest | Igetion | | | M 1 | Yes 2□No | | | | |
| Division of Vital Records, | after d Direct d in by | Certification: | 3 ☐ Sulcide 6 ☐ Could 4 ☐ Homlcide detern | nined 286. Piece of | Injury - At ho , etc. (Specify | me, ferm, st | reet, fectory, office | | 28f. Location (5 City or Tox | | er or Rural | Route Number, |
| | To the Hespital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completaly filled in by the funeral | edical C | 29a. Certifier 1 Certifyin (Check only one) 1 Medical | ng Phyeician: To the best | s of exeminet | wledge, deet lon end/or in | h occurred et the ti vestigetion, in my o | me, date end pleca opinion, deeth occu | , end due to the erred et the time, | cause(s) end ma dete end plece, | end due to | ited. the cause(s) |
| | Nithin Fo the | M | 29b. Signeture end title of denific | | | | 29c. Licens | se number | | 29d. Dete signe | d (Month, D | ley, Year) |
| N | ->-0 | | MI M | 1 1 | MA | | AT 2 | V20011 | , 1 | 1,0,1 | 20 | 10197 |
| | 723 | | 30. Neme and address of person | who completed cause of | of deeth (Item | 23e) (Type. | Print) | · PKWY | 6 | Tugus! | 11 | ו קא |
| | 21 | | JOHN AL- | JAMAI. | 2 00 | Z | UNIO | PKWY | RAT | TO. H | 10 | |
| | CA | | 31. Dete filed (Month. Dev. Year |) 32 Regi | istrer's Signe | ure | | | 771 | | | , |

Registrar

Hugust 22/997 DAUG 25 1997 Sin Minder Radall

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene -Amend # 5, 8/28/97, BMW, Montg. Co Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath **Physician** THOMAS AUGUST 21,1997 PATRICK KILROY 03:50a.m /Medical 4a. Facility Nama (If not institution, giva street and numbar) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick

If Undar 1 Year | If Undar 24 Hrs. | 8, Data of Birl 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funerai** Birthplace (Stata or Foreign Country) 15 M 2□ F Days Hours Min. Yrs. Director 89 Sep. 23, 1907 Washington.D.C. Usual Rasidance of Dacedant with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be notified at 1 ☐ Yas 2 ☐ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 15316 Durant Street Funeral 20905 U.S.A. 14. Race - Amarican Indian, deeth 12. Was Decedani Evar in U,S.
Armed Forcas?

1 △ Yas 2 □ No
If Yas, Giva
Yaar or Datas: ₩₩ II 13. Was Dacedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) Black, Whila, atc. filed within 72 hours after 1 Navar Married 2 Married 21215-0020 1 Yas 2 XNo Specify þ 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedant's Education (Specify only highast grada complated) 18a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry I Hygiene. Elemantary/Secondary (0-12) Coilega (1-4or 5+) Self-Employed Dry Cleaning Baltimore, Maryland 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) . Pages 1 and 2 should be fill ment of Health and Mental Hyant: If them 27 is marked oth lury or other traumatic even Be Eugene Kilroy Lillian Rabbit 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Dennis E. Kilroy 15316 Durant Street Silver Spring, Maryland 20905 20a. Mathod of Disposition 20b. Place of Disposition (Nama of camatary, cramatory or other place) 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramovai from Stata permit. Page Department o Important: If i any injury or 4 □ Donation 5 □ Other (Specify) Gate of Heaven Cemetery 8/25/97 Silver Spring, Maryland M Funaral Sarvice Licenses Francis J. Collins Funeral Home, Inc. neneu 500 University Blvd., W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or com shock, or haart failura. List only plidations that caused the death. Do not antar the mode of dying, such as cardiac or respiratory errest, the cause on each line. Approximata Interval Between Onsat and Death **Physician** /Medical Immediata Causa (Final . PULMOLART EMBOLUS disaasa or condition rasuiting in death) MINUTES Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, laading to Immadiata causa. Enter Underlying Causa (Disaasa or Injury that initiated evants rasuiting In death) Last Dua to (or as a consequence of) Box 68760, Physician/Medicai Dua to (or as a consequence of) signed by the attent Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown OSTEO ARTHRITI Division of Vital Records. þ 24b. Wara autopsy findings availabla prior to completion of cause of daath? 24a. Was an autopsy performed? Completed CORDNARY ARTERT DISFAL page 2 this cartificate 1 Yas 2 No 1 ☐ Yas 2 ☐ No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this cardifica completely filled in by the funeral director, p 25. Was casa rafarred to madical axaminar? Be 26. Placa of Death (Check only ona) Hospitai: 1 Suppatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yas 2 € 27. Manner of Death Certification: 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how Injury occurred 28b. Time of 5 Panding invastigation 1 Natural 1 Yas 2 No 2 Accident 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicide 1 🖵 🗲 Cartifying Physician: To tha bast of my knowladga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 29a, Cartifiar Medicai

(ot

State Registrar

John H. Weigel, M.D. AUG 25 1997 31. Date filed (Month.

(Check only one)

29b. Signatura and titie of certifian

Prince Frederick, Maryland 32. Registrar's Signatura Julia Davidson-Randoll

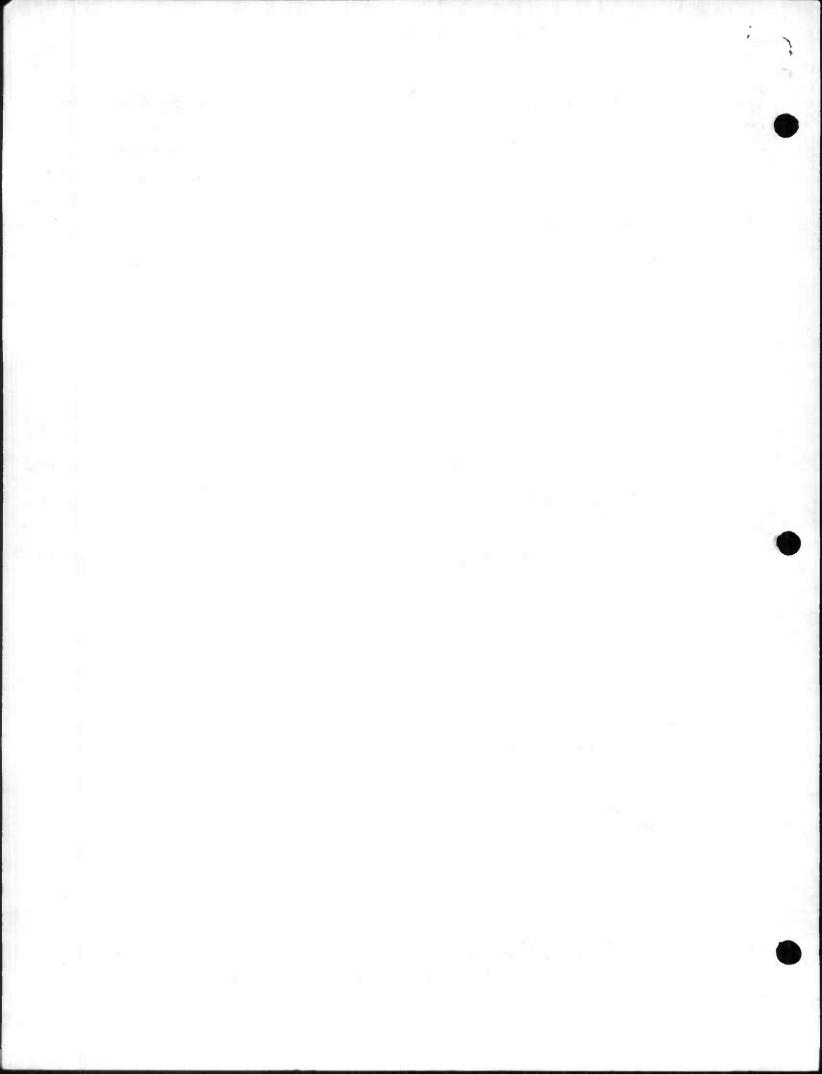
drass of person who complated cause of death (Itam 23a) (Type, Print)

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licansa number

29d. Data signed (Month, Day, Year)

AUG. 21, 1997



State of Maryland / Department of Health and Mental Hygiene 97 27185

| sician edical | | | | | OUIL | ificate | or Douter | | Reg. No. | | |
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| | 1. Decedent's Nem | ne (First, Middle, I | ast) | 12 | | | | 2. Dete of De Month | eth Dey | Yeer | 3. Time of Dear |
| ulual | | Barbar | a Fisher | Korzen | ndorfer | | | August | | 7 | 7:15 AM |
| miner | 4e. Fecility Neme (i | (If not institution, g | rive street and numi | ber) | | | 4b. City, Town, o | r Location of Deeth | 4c. County | of Death | |
| | SHAD | Y GROVE | ADVENTIS' | T HOSP | ITAL | | ROCKV | TLLE | MON | VIGOM | ERY |
| ı | 5. Sociel Security N | | Sex 7 1 □ M 2 🖾 F | . Age (in yrs. | , | If Under 1 Y Months D | ear If Under 24 H | S. 8. Dete of Birt | h y, Year) | 9. Birth | plece (State or For |
| | 165-28-93 | | TEIW ZEEF | 62 | Yrs. | | | May 24 | | Penn | sylvania |
| | Usuel Residence of 10e. State | 10b. County | | 10c Cit | y, Town or Loca | ation | | | | Τ. | 10d Incide Chyllis |
| 7 | A COLON | | | | | | | | | | 10d. Inside City Lir 1 ☑ Yes 2 ☐ |
| Director | Maryland | Montgo | omery | | Rockvil | | | 1 | | | |
| Dir | 10e. Street end Nur | | | | | 10f. Zip Co | | | 10g. Citizen of \ | What Cou | ntry? |
| ra | 703 Moni | roe Stre | | | | | 850 | | United | | |
| Funeral | 11. Meritel Status | | 12. Wes Deced | ces? | ,S. 13. W | es Decedent Yes, specify | of Hispenic Origin? Cuben, Mexicen, Pue | (Specify Yes or No arto Ricen, etc.) | - 14. Red Bie | e - Americk, White, | can Indian, etc. |
| | | ried 2 Married | If Yes, Give | | 10 | □Yes 2⊠ | No Specify: | | Specify | V: | |
| d by | 3 🖾 Widowed | | Yeer or Det | les: | | | | | | Wh: | ite |
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| | 47 Fall of Name | /F' 14:14: 1 - | 1 | | Car | egive: | | | Health | | е |
| Be | 17. Fether's Neme | | | | | | | eme (First, Middle, | | | |
| To | Owen Lan | mont Fis | ner, Sr. | | | | | lorence P | | | |
| | 19e. Informant's Na | • | | | | | reet end Number or I | | | | |
| | Florence | | Sister | | | | n Avenue, | Bethesda | , Maryl | and 2 | 20817 |
| | 20e. Method of Disp | | ☐Removet from St | 20b. P | Piece of Disposition of the property of the pr | tion (Name o story or other | plece) Aug. 2 | Date 3 1007 | 20c. Location - | Clty or To | own, Stata |
| | | 5 Other (Spec | | Mon | ntgomer | y Crem | atorium, | Inc. | Betheso | ia, M | laryland |
| | 21. Signature of Fu | uneral Service Lic | ensee | | - | * | dress of Fecility | | | | |
| any Injury or other traumer | No sa | 1.20 | | M0019 | . 30 | 0 West | Montgome Le, Maryla | ery Ayenu | e | OCKVI | rrre, Inc |
| | 23a, Pert1. Enter t | de disease, or co | mplications that cau | | h. Do not enter | the mode of | dving such es cardi | and 2085 | 0-2805 | | Approximete |
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| ettending physician and for use as the buriel-transit clan/Medical Examiner | Sequentially list coif any, leading to im | onditions, | b | Due to (o | r es e conseque | | | | | | |
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| Completed by Physician/Medical | Ceuse (Disease or that initiated events resulting in death) I Pert II. Other signif | flicent conditione | | Due to (or | r es e conseque | ance of): | | 1 24a. Was perfo | Yes 2□ No en eutopsy med? Yes 2□ No | 24b. W | Vere autopsy finding veitable prior to ompletion of cause deeth? |
| Be Completed by Physician/Medical | Course (Dissess or that initiated events resulting in death) I | flicent conditione | PRESS | Due to (or | r es e conseque | ence of): ence of): lerlying ceuse | 26. Piece of D | 24a. Was perfo | Yss 2□No en eutopsy med? Yes 2□No | 24b. W ev cc of | Vere autopsy findin veilable prior to ompletion of cause deeth? |
| To Be Completed by Physician/Medical | Pert II. Other signif 25. Wes cese referexeminer? 1 Yes 2 1 27. Menner of Deeti | ficent conditions rred to medicei | PRESS | Due to (or | r es e conseque r es e conseque ulting in the und | ence of): ence of): lerlying ceuse | 26. Piece of D Other: 4 □ Nursing | 24a. Was perfo | Yss 2□No en eutopsy med? Yes 2□No | 24b. W ev cc of | Vere autopsy findin veilable prior to ompletion of cause deeth? |
| To Be Completed by Physician/Medical | 25. Wes cese referencements. 25. Wes cese referencements. 27. Menner of Deett 1 Neturel | ficent conditions CDN rred to medicei | Hospitel: 1 Am | Due to (or | r es e conseque r es e conseque ulting in the und | ence of): ence of): errying ceuse 3 □ DOA 28c. | 26. Piece of D | 24a. Was perfo | Yss 2 No en eutopsy med? Yes 2 Abo ene) dence 8 Oth | 24b. W ev cc of | Vere autopsy findin veilable prior to ompletion of cause deeth? |
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| Certification: To Be Completed by Physician/Medical | 25. Wes cese reference were larger to the control of the control o | ficent conditions fred to medicei ficent conditions fred to medicei ficent conditions fred to medicei ficent conditions fred to medicei fred to medicei | Hospitel: 1 28e. Dete of (Month, on be d 28e. Piece o building | Due to (or th but not result thing the patient 2 thing the patien | EP/Outpatient 28b. Time of Injury Dome, farm, streety) | ance of): ance of): derlying ceuse 3 □ DOA 28c. M et, fectory, off | 26. Piece of D Other: 4 □ Nursing Injury et Work? 1 □ Yes 2 □ No | 24a. Was performed to the control of | en autopsymmed? fes 2 1 No dence 8 Oth how injury occur Street and Number, State) | 24b. We ever of final states of the control of the | Vere autopsy findin veilable prior to ompletion of cause deeth? Yes 2 No Yes 2 No |
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| edical Certification: To Be Completed by Physician/Medical | 25. Wes cese reference of the initiated events resulting in deeth) I Pert II. Other significant of the initiation of th | Injury Lest Ilicent conditione Tred to medicei | Hospitel: 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | Due to (or th but not result patient 2 thing the patient (or patient) It njury (or patient) If thing At hog, etc. (Specify the patient) rest of my know is of examinet or stated. | ER/Outpatient 28b. Time of Injury ome, farm, streety) | ance of): | 26. Piece of D Other: 4 Nursing Injury et Work? 1 Yes 2 No ice ice time, dete end ple ny opinion, deeth oc | 24a. Was performed to the courred et the time, and due to the courred et the time, and the courred et the cour | en eutopsymmed? Yes 2 DNo en eutopsymmed? Yes 2 DNo one) dence 8 Oth now injury occur Street end Numb cause(s) end mid date end plece, 29d. Dete signe A U C U S T | 24b. We ever considered anner as a end due to de (Month, | Visably 4 Unkr Vere autopsy findin Veilable prior to Ompletion of cause deeth? Yes 2 No Very |

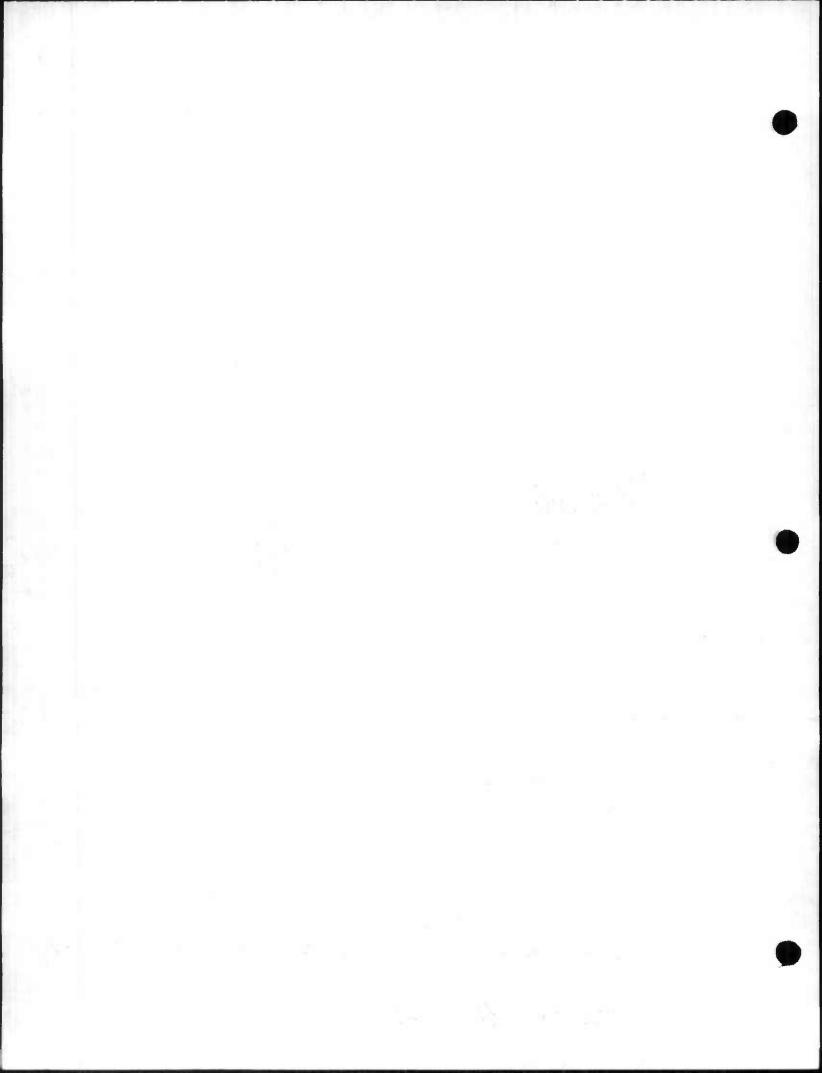
Registrar

State of Maryland / Department of Health and Mental Hygiene Q 7

| _ | | | | | tificate of | Death | R | eg. No. | | 36 |
|---|------------------|---|--|--|---|--|---|---------------------------------------|--|---------|
| Physicia | | Decedent's Neme (First, Middle, Last) CATHER | INE K. LAKE | | | | 2. Dete of Deet Month AUG • 2 | Dey | 3. Time of 6:40 | |
| /Medic Examin | | 4e. Feclity Neme (If not institution, give : NATIONAL LU | street end number) | | | 4b. City, Town, or Lo | cation of Deeth | 4c. County | | |
| Funerai Director | | Sociel Security Number 6. Security Number | | | If Under 1 Yeer Months Deys | | 8. Date of Birth (Month, Dey, JAN • 4 | Year) | 9. Birthplece (State Country) -MARYLAN | or Fore |
| 72 hours effer death with the Maryland natural; or items 23a or 28a-f show tigal Examinet must be notified at | tor | Usuel Residence of Decedent 10e. State 10b. County BALTIMOR | | r, Town or Lo | cation TIMORE | | | | 10d. inside (| |
| 23a or 28a-f show | ai Director | 10e. Street end Number 116- W. UNI | VERSITY PAR | KWAY | 10f. Zip Code 2 | 1210 | 10 | 0g. Citizen of V USA | | |
| n "netural", or items | by Funeral | 11. Maritel Status 1 ☐ Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | I2. Wes Decedent Ever in U, Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Detes: | H | Ves Decedent of Yes, specify Cub | Hispanic Origin? (Speen, Mexican, Puerto Specify: | ecify Yes or No- Rican, etc.) | Blec | e - American Indien, ek, White, etc. :: WHITE | |
| than | Completed | 15. Decedent's Educ (Specify only highest grade Elementery/Secondary (0-12) 1.2 | cation completed) College (1-4or 5+) | | ent's Usual Occu kind of work done OONOT use retire | petion during most of working) NG | ing | | INOWN | |
| d other | To Be Co | 17. Fether's Neme (First, Middle, Last) LOUIS C • A • | KOOP | | | 18. Mother's Name | (First, Middle, A | Aeiden Sumem | | |
| th and 7 is m traum | | 19a. Informent's Neme/Reletionship (Type REV • DR • RICHARD | | | | s ond Number or Rure S DRIVE, | | | | |
| nent of ant: if it | | 20e. Method of Disposition 1 ☐ Buriel 2 🖾 Cremetion 3 ☐R: 4 ☐ Donetion 5 ☐ Other (Specify) | emovel from State MET | ece of Disposementery, crem ROPOL | sition (Neme of retary or other ple ITAN C | REMATORY | Dete -8/4 | | City or Town, Stete | ٠. |
| Depenting any injura | | 21. Signetate of Funerel Seamo License | e Enclose that caused the deeth | | | CO., INC | | | 2 | |
| g physicia es the bur | ledicai Examiner | tmmediete Ceuse (Finel diseese or condition resulting in death) Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest | Due to (or | as e consequence as e c | uence of): | 'n Dis | eas | · · · · · · · · · · · · · · · · · · · | 1 20h | ew |
| | Physician/M | d | | | | | | | | |
| wen signed by the attendin hould be detached for use | by Physi | Polymyosths | chonic | lting in the un | truck | ven in Pert i. | 100 | | atributa to the cause 3 ☐ Probably 4 ☑ | |
| pinould | Completed | Pulmonary 1 | Disease, | , De | verle | ulo 37 | 24e. Wes ar perform | n autopsy ned? | 24b. Were autopsy evellable prior completion of of death? | to |
| s certificate has b | Be | 25. Was case referred to medical exeminer? | deny test | re | Ott | 26. Plece of Deeth | | 9) | 1 ☐ Yes 2 ☐ | No |
| al da | n: To | 1 Yes 2 No | | ER/Outpetient 28b. Time of injury | 3□ DOA 28c. Inju | Nursing Hor | ne 5∐ Reside 28d. Describe ho | | | |
| after death. Director: After in by the fune | Certification: | 1. Neturel 5 Pending Investigation 3 Suicide 6 Could not be determined | 28e. Plece of Injury - At hor building, etc. (Specify) | me, ferm, stre | M 1□ | Yes 2□No | 28f. Location (Str City or Town | reet end Numbe , Stete) | er or Rurel Route Nun | nber, |
| | edical Ce | 29a. Certifier (Check only one) 1 Certifying Physical Examination | cian: To the best of my know ar: On the besis of examineti end manner steted. | riedge, deeth on end/or inve | occurred et the tilestigetion, in my o | me, dete end plece, e | and due to the ca | use(s) end mer | nner es stated. and due to the cause(| s) |
| within To the compl | Σ | - 4000 | nu v | 40 | 29c. Licens | 366/5 | 3 25 A | Od. Dete signed | (Month, Dey, Year) | 9- |
| Stat | | 30. Neme end address of person who cor DR • CHRISTOP 31. Dete filed (Month, Dey, Year) | HER SCHEMM— 32. Registrer's Signetic | 9701 | | S DR., R | OCKVIL | LE,MD. | 20850 | |

Registrar

DHMH 16 Rev 6/95



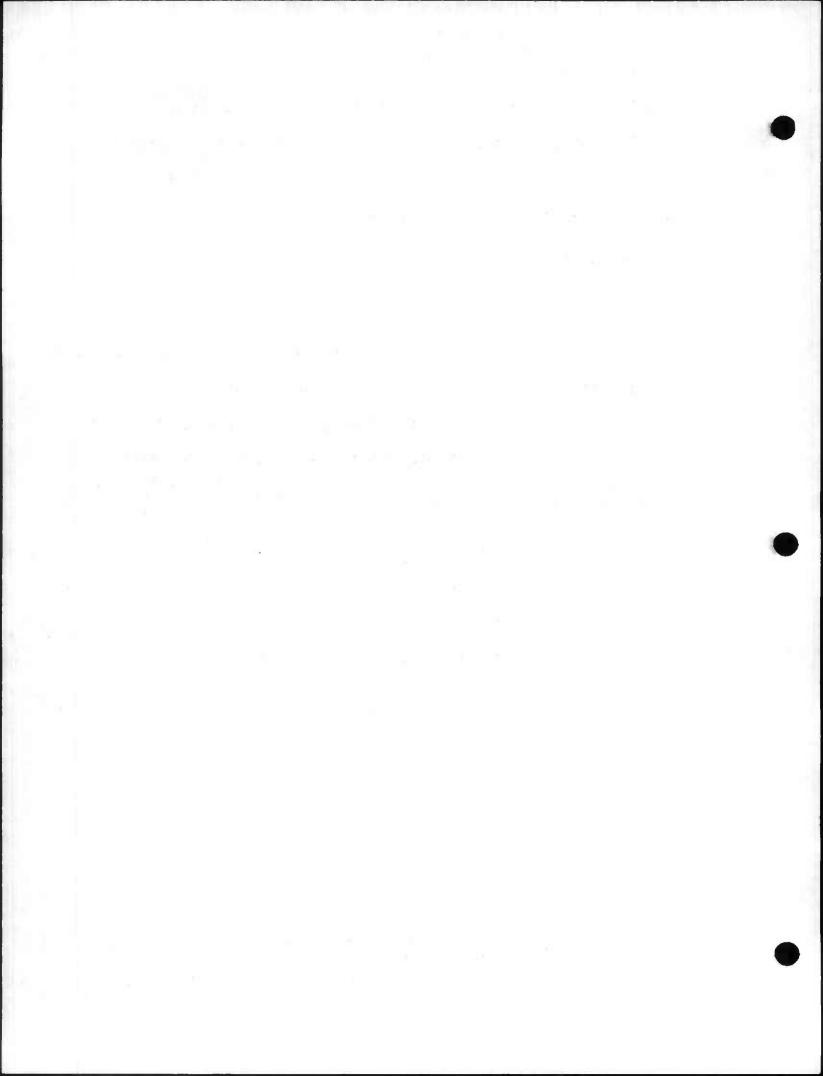
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 27 187

| | | | | | , | Certificate o | f Death | | eg. No. | 21101 |
|---------------------|---|------------------|--|--|--------------------|--|---|---|--|---|
| П | Dhysisi | | 1. Decedant's Nama (First, Middla, La | st) | | | | 2. Data of Dear | - | 3. Time of Death |
| J | Physici /Medi | | JOHN BARW | ICK LOM | AX | | | AUG. | 22 1997 | |
|) | Examir | ner | 4a. Facility Nama (If not institution, giv | | | | 4b. City, Town, or L | | 4c. County of D | |
| L | | | | ENESIS EI | | | EASTO | | | ALBOT |
| | Funeral Director | | 5. Social Security Number 219-07-5787 Usual Rasidance of Decedant | 2 F 8 C | (In yrs. last bir | Yrs. Months Day | Hours Min. | 8. Data of Birth (Month, Day, OCT - 31, | Year) 1916 M | Birthplace (Stata or Foreign Country) LARYLAND |
| | yland | | 10a. Stata 10b. County | | 10c. City, Town | or Location | | | | 10d. Inside City Limits |
| | Mar Mar | ctor | MD TALBO | TC | | TILGHMAN | | | | 1 XYas 2 □ No |
| | th with the 23a or 28 | ai Director | 10e. Street and Number 21489 ELMER ST | г. | | 10f. Zip Code | 21671 | 1 | 0g. Citizan of What USA | Country? |
| 020 | Juithin 72 hours after death with the Manyand Jena. I than "naturat", or items 23s or 28=4 show the Modical Examiner must be notified at | by Funerai | 11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedant I Armed Forces? 1 X Yas 2 N If Yas, Giva Yaar or Datas: | | 13. Was Decedant of If Yas, specify Co | f Hispanic Origin? (Sp uban, Maxican, Puarto lo <i>Specify:</i> | ecify Yas or No- Rican, atc.) | | marican Indian, /hita, atc. /HITE |
| 5-0 | 72 h | Completed | 15. Decedant's Ed (Specify only highest gra | | 16a. | Decedant's Usual Occ (Giva kind of work dorn lifa. DO NOT usa reti | supation na during most of work | sina | 16b. Kind of Busine | ss/Industry |
| 121 | within ena. then the | mpi | Elamantary/Secondary (0-12) | Collega (1-4or 5 | +) | `iifa. DO NOT usa reti TERMAN | red) | | SEAFOOD | INDUSTRY |
| d 2 | e filed offher vent, ti | | 17. Father's Nama (First, Middle, Last) | 1 | AAT | LIMAN | 18. Mother's Nem | a (First, Middle, I | | INDUSTRI |
| lan | should be nd Mental marked o | To Be | JOHN B. LOMAX | | | | | SINCLA | | |
| Maryland 21215-0020 | 2 sh and is m | 1 | 19a. Informant's Name/Ralationahlp (KATHERINE LOMA) | | 19b. | Mailing Addrass (Stre | 82, TILG | rai Routa Number HMAN, N | City or Town, Stat | a, Zip Code) |
| Baltimore, | Pages 1 and nent of Haalth int: If Item 27 ary or other to | | 20a. Mathod of Disposition 1XX uriai 2 Cramation 3 4 Donation 5 Other (Specify | | cematar | Disposition (Nama of y, cramatory or other p | CEMETER | | 20c. Location - City TILGHM | or Town, Stata |
| Balt | pemilt. Page Department of Important: If I any injury or once. | | 21. Signature of Funaral Sarvice Licen | nsee In | CFCF | | | | | FUNERAL HOM |
| | Physician /Medical Examiner | J.C | 23a. Part1. Enter the disease, or com shock, or heart feilure. List only Immediate Causa (Final disease or condition resulting in death) | e. | W. | Sonsequence of): | All All All All All All All All All All | elle | Alle V | Approximeta Interval Between Onset and Death |
| x 68760, | ertificate be axecuted ling physician and a as the burlat-transit | Medical Examiner | Sequentially list conditions, if any, laading to Immadieta cause. Entar Underlying Cause (Diseasa or injury that initiated events rasulting in deeth) Last | c | Due to (or as a c | onsequence of): | il Wi | aru | (WEV N | y yges. |
| Box | ath catherd | ian | 1 | - | | | | | | |
| 0 | tha death ce y the attendia sched for use | Physician/N | Part II, Other significant conditions of | uting to death bu | t not rasulting in | tha undarlying causa | given in Part I. | 23b. Dld to | V | uts to the cause of death? |
| S, G | ires that tha death cer signed by the attendir d be detached for usa | by Pt | Mum | ll | | | | 1 🗆 Yı | 2 No 3 | Probably 4 Unknown |
| Vital Records | been shoul | Completed b | | | | | | 24a. Was a perform | | lb. Wara autopsy findings availabla prior to completion of causa of death? |
| Ä | The law ta has saga 2 | E O | | | | | | 1□ Ya | s 2D No | 1 Yas 2 No |
| <u>Ta</u> | delen: The | Bec | 25. Was casa refarred to medical | | | | 26. Placa of Deet | h (Check only on | a) | |
| | Physics this can ral direct | 2 | axaminar? 1 ☐ Yas 22 No | Hospital: 1 Inpatie | nt 2 ER/Out | tpatient 3 DOA | Other: 4 Nursing Ho | oma 5 🗆 Rasida | nce 6 Other (S | Specify) |
| Ē | Attending Physician: sr death. ector: After this cartific by the funeral director. | on: | 27. Mennar of Death 1 ☑ Netural 5 ☐ Pending | 26a. Data of Injur (Month, Day | | njury W | Pork? | 26d. Dascribe ho | w Injury occurred | |
| Sio | ttendi death tor: / the f | icat | 2 Accident invastigation 3 Suicide 6 Could not be | | | | ☐ Yes 2 ☐ No | 29f Leasting /Ct | and and blombar as | Burni Bouto Mumbar |
| Division of | after deat Director: J in by the | Certification: | 4 ☐ Homicide datarmined | building, atc | | m, streat, factory, offic | 9 | City or Town | | Rural Routa Number, |
| | To the Hospital or Attanding Physician: The I within 24 hours after Goath. To the Funeral Director: After this cardificate he completely filled in by the funeral director, page | edical C | 29a. Certifier (Check on 2 Medical Example) | ysician: To the best of liner: On the basis of and manner sta | axamination and | death occurred at the for invastigation, in my | tima, data and place, opinion, daath occur | and dua to the co | usa(s) and manna ata and place, and | r as stated. dua to tha causa(s) |
| | of the | Me | 29b. Signature and title of certifier | 110 | 1 | 29c. Lica | nse number | , 2 | 9d. Data signed (M | onth, Day, Year) |
| | ->-0 | | VKtring! | 1/LATK | (171) | \square | 11308 | | 8-22. | -47 |
| | | 1 | 30. Name and address of person who | completed causa of de | ath (Itam 23a) (| Type, Print) | | | | -/ |
| | | | R. LANE WROTH | , M.D., I | P.O. BO | OX 290, S | T. MICHA | ELS, MI | 21663 | |
| | Sta Registr | _ | 31. Data filed (Month, Day, Year) AUG 2.5 19 | | r's Signatura | Burdage | | | | |

State of Maryland / Department of Health and Mental Hygiene 97 27 188

| | | | | | | Cei | rtificate d | of Dea | th | | Reg. | No. | | |
|--------------|--|----------------|---|--|---------------------------------|---------------------------------|-----------------------------------|-----------------------------|---------------------------|-------------------------------|----------------------|--------------------------|----------------------------|-------------------------------------|
| | Physici /Medi | | 1. Decedent's Name (First, Mid | CEW | ELLIN | 5- L | YNCH | (| | 2. Date of I Month AUGU | Death | Day | Year > | 3. Time of Death |
| 1 | Examir | | 4a. Facility Neme (If not instituti | on, give street end | number) | | | 4b. City | Town, or L | ocation of Da | eth | 4c. County | | |
| | = Addiiii | | Carroll Coun | ty Gene | ral Hos | pita1 | | Wes | tmin | ster | | Carı | ro11 | |
| | Funeral | | 5. Social Security Number | 6. Sex | 7. Age (In yrs. | | | ear If Un | der 24 Hrs. | 8. Date of E | Birth | | 9. Birthpl | ace (Stete or Foreign |
| | Director | 7 | 408-44-8478 Usual Residence of Decedent | 1□ M 2CN | 68 | Yrs. | Months Da | iys Hou | rs Min. | Nov. | 7 , 1 | 928 | Ten | try) |
| | show | | 10a. Stete 10b. Coun | у | 10c. Cit | y, Town or Lo | cation | | | | | | 10 | Od. Inalde City Limits |
| | Mary 1 | ō | Md Car | roll | | Westm | inster | - | | | | | 1 | 1⊠ Yes 2□No |
| | 150 the | Director | 10e. Street and Number | | | | 10f. Zip Cod | la | | | 100 | Citizen of V | Vhet Count | trv? |
| | With the second | | 81 John Str | | | | | | | | | | | |
| | 23 at | Funeral | | | anadast Francis II | 0 40 1 | 2115 | | 0-1-1-0 (0- | | 1 | ited | | |
| | er de | Š | 11. Maritai Status | | ecedent Ever in U Forces? | ,5. 13. | Was Decedent If Yes, specify (| Cuban, Mex | ican, Puerto | Rican, etc.) | NO- | | e - America k, White, e | |
| 21215-0020 | 72 hours after death with the Maryland naturel', or itema 23a or 28a-f show 3-xal Examiner must be notified at | þ | 1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 🖾 Divorce | If Yas, | s 2⊠No Giva r Dates: | | 1 □ Yes 2 🔯 | No Spec | elfy: | | | Specify | Wh | ite |
| 5-0 | be filed within 72 hours ital Hygiene. d other than "naturel", event, the Med cal Exa | Completed | 15. Decede | ent's Education est grade complete | adl. | 16a. Dece | dent's Usuai Oc | cupation | nost of work | vina | 16b. | Kind of Bu | siness/Ind | lustry |
| 21 | within sene. | ple | Elamantary/Secondary (0-12) | - i | a (1-4or 5+) | | kind of work do DO NOT use re | | | uig | | | | |
| 21 | filed within Hygiene. ther than ent, the Me | ρο. | 8 | | | Soc | ial wo | orker | | | He | omele | ess s | shelter |
| b | offied other vent, th | Be | 17. Father's Name (First, Middle | i, Last) | | | | 18. M | other's Nam | a (First, Midd | la, Maid | en Sumam | e) | |
| Maryland | | ToE | Carl Lewel | ling | | | | Le | ttie | Lane | | | | |
| ary. | SPEE | | 19a. Informant's Name/Relation | ship (Type, Print) | | 19b. Maiiii | ng Address (St | reet and Nu | mber or Rui | ra/Route Nurr | ber, Cit | y or Town, | State, Zip | Code) |
| | d 2 | | Rodney Lynch | /son | | 103 | Libert | v St | Wes | +mine | Far | Md ' | 2115 | 7 |
| a) | - 7 5 5 | | 20a. Method of Disposition | , 5011 | 20b. F | Place of Dispo | sition (Name o | 1 | ·WCB | Date | _ | Location - | | |
| 0 | nt of If it | | 1 Burial 2 ☐ Cremation | | | | ster (| place) | 8/26 | | | stmin | | |
| altimore, | mit. Pe vartmen cortant: injury | | 4 □ Donation 5 □ Othar (| | | | | | | | | | | |
| Bal | permit. Peges Department of Inportant: If ite any injury or of | | 21. Signature of Funeral Service | A. / | nev | | Name end Ad Yers I | | | 91 ome _{We} | Wi. | llis inste | Streer, Mo | eet d 21157 |
| | | | 23a. Part1. Entar the disease, shock, or heart failura. Lie | or complications the | at caused the deat | | | | | | | | | Approximata |
| J | Physician | | snock, or near failura. Lis | st only ona cause o | n eachuine. | | | | | | | | | intarvai Batween Onset end Death |
| | /Medical | | Immediate Cause (Finai | AC | ute a | WAA. | 11010 | 1 T | NEA | 10 De | 2) | | - 1 | 1 11000 |
| | Examiner | | diseese or condition resulting in death) | a | | | | C 1. | 10/71 | 100 110 | | | 1 | THOUR |
| | | ē | | 0 | | or as a consec | | | | | | | 1 | 110 (1011) |
| | nsit | 盲 | | bK | entL | | | _ | | | | | | 10 year |
| | ertificate be executed ling physician and e as the burial-transit | Examiner | Sequentially list conditions, if any, leading to immediate | 0. | 4 4 | or as a consec | | 21 | | | | | 1 | 104011 |
| 68760, | be | | cause (Disaasa or Injury that initiated evants | 6. PI | ABETC. | | ECLI | 113 | | | | | İ | 107 EAR. |
| 387 | physicate s the | Medical | rasulting in death) Last | | | r es e conseq | | 0 | | | | | 1 | |
| 34 | 2 5 8 | | | d. C01 | ronary | AN | Tery | 1)1. | 124) | ٤ | | | 1 | , oyean |
| Bo | te at o | Physician | Dort II. Other elemidianet condi | lama a satisficación de la constantidad de la const | advedte best and an | obto a to short | | | - 4.1 | ant Di | dahaa | | | |
| 0 | that the de ed by the e | Jys | Part II. Other algnificant condit | | | | | | | | | | | the cause of death? |
| 9 | es that igned b | | CHNONIC | OBSTAC | CHUC | 100 | LMON | ANG | 1 | 11 | _ Y 00 | 2□ No | 3 Prob | ably 4/2 Unknown |
| ds, | sign d be | d by | | | | | | | | 24a. Wa | ac an ai | itonev | 24b. Wa | ra autopsy findings |
| Ö | v require been si should | ete | 1) IJEAJE | | | | | | | ре | rformed | 1 | cor | npletion of ceuse |
| 360 | S C | Completed | | | | | | | | | | | of | death? |
| 1 | | S | | | | | | | | 10 | Yes | 2EINo | 1 🗆 | Yes 20 No |
| Vital Record | ysician: s certific director, | Be | 25. Was cese referred to madic exeminer? | | | / | | | lace of Dea | th (Check only | y one) | | | |
| of | | 2 | 1 ☐ Yes 2 ☑ No | Hospitai: | ☐ Inpatient 2 ☐ | ER/Outpatier | nt 3□ DOA | Othar: 4 | Nursing H | ome 5□Re | sidence | 6 □Oth | er (Specify |) |
| D C | Jing Ph J. After th funeral | ü | 27. Manper of Death 1 Natural 5 □ Pend | | ta of Injury onth, Day Year) | 28b. Time of Injury | 28c. I | njury at Work? | | 28d. Describ | e how in | jury occurr | red | |
| Division | | atic | 2 ☐ Accident Inves | tigation | | 1000 | | 1 ☐ Yes 2 | No | | | | | |
| Vis | or Attendation of Attendation of Director: | tiffe | 3 ☐ Suicide 6 ☐ Could 4 ☐ Homicida deter | mined 288. Pla | ace of Injury - At h | ome, farm, str | eat, factory, off | ice | | 28f. Location City or 7 | | | er or Rura | Route Number, |
| Ö | s afte | Certification: | / I romoida | 00 | ilding, etc. (Specil | y/ | | | | Ony or 1 | Own, St | 210/ | | |
| | To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the | edical (| 29a. Certifier (Check only one) 1 Certify 2 Medica | ing Physician: To t I Examiner: On the | basis of examina | wiadga, death tion and/or in | occurred at the | e time, data ny opinion, | and piaca, death occur | end due to the | a causa e, date e | (s) end ma end place, | nner as st | ated. the cause(s) |
| | To the within 2 To the comple | Me | 29b. Signeture and title of certific | 111.77.11 | anner statad. | | 29c Lio | ense numb | er | | 29d I | Dete signed | 1 (Month I | Day Year) |
| | F ₹ F 8 | | 1/. // | Colone | 11. | 110 | | | | / | | | | |
| | | | Wounty. | Schrie | y der | | U | 00 | | / | H | 1003 | 10 | 7, 1977 |
| | | | 30. Name and addrass of person | | sa of death (Iter | 23a) (Type, | Print) | | Aniba | 100 | MI | The | ITOA | 3, 1997 MANYLA |
| | | | DAN It. SCHA | (15/2011 | (M) | LOV | MYMO | UAL | TVE | U SU | 700 | טודיו | J/7C | MANAYLA |
| | Sta | | 31. Data filad (Month, Day, Yea | 1007 32 | Registrar's Signa | ture | .4 | | | | | | | 61157 |
| | Registr | ar | AUG 2 | 199/ | upa dimete | orphanol | Ц | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month August EDWARD MATTHEW LIPO 1997 21 /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 1620 Liberty Grove Rd. Conowingo Cecil If Under 1 Year If Under 24 Hrs. Hours Min. 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Day, Year) Birthplece (Steta or Foreign Country) **Funeral** Months Deys 1**2** M 2 □ F 436-09-1785 Vre Director 80 Oct. 13, 1916 Maryland Usuat Residence of Decedant 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Cecil Directo Conowingo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1620 Liberty Grove Rd. 21918 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus 14. Race - American Indien, Bleck, White, etc. 1 X Yes 2 □ No If Yes, Give Yeer or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 KNo Specify: þ Specify 3 Widowed 4 Divorcad White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elemantary/Secondery (0-12) College (1-4or 5+) Superintendent Shipping 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumema) Matthew (u/k)Lipo Bernice (u/k) 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) Irene C. Lipo - wife 1620 Liberty Grove Rd., Conowingo, MD 21918 20b. Plece of Disposition (Name of cemetery, crametory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 8-23-97 W. Chester, Pa. A. Ferris & Co. 22. Name and Address of Facility
Howard K. McComas III Funeral Home, P.A
Abingdon, MD 21009 21. Signature of Manerel Service Licensee 23a. Pert1. Entar the disease, or complications that beused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or haart failure. List only one cause of each lina. **Physician** Immedieta Cause (Final diseasa or condition resulting In death) /Medical **Examiner** Dusto (or as a consequapee of): Examiner Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Undarlying Ceuse (Diseese or Injury that Initieted events resulting in deeth) Last Due to (or es e consequence of) Physician/Medical Due to (or es e consequença of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contributa to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings eveilebla prior to completion of cause of death? 24e. Wes an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarrad to medical exeminer? Be 26. Placa of Deeth (Check only ona) Hospital: 1 Yes al No Othar: 4 Nursing Home 5 Presidence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Daath 1 DNeturel 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, atc. (Spacify) 4 Homicide 29a. Certifier Medicai Certifying Physicien: To the best of my knowledge, daeth occurred at the time, dete end piece, end due to the ceuse(s) end manner as stated. Medical Examinar: On the besis of exeminetion end/or invastigation, in my opinion, deeth occurred et the time, deta and place, and dua to the cause(s) end manner stated. (Check on!) one 29b. Signature and Ittle of certifie 29d. Date signed (Month, Dey, Yeer) 48066

MA

Registrar

eddrass of person who complated cause of death (Item 23e) (Type, Print)

her

kund

the Maryland

with

death

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Modical Examinar must be notified at

should be filed within 72 hours after and Mental Hygiene.

permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, important; if feen Z7 is marked other any injury or other traument.

B

physician

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certificate

Ather

Director:

or A

To the Hospital within 24 hours a To the Funeral C

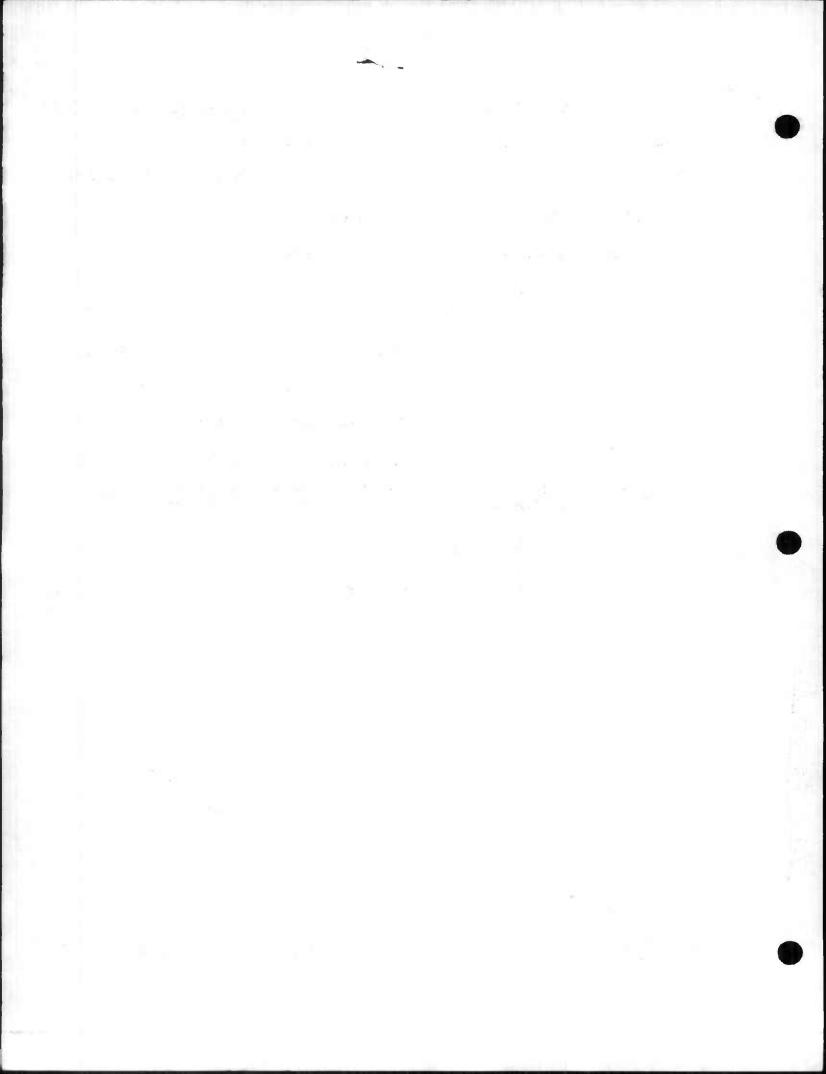
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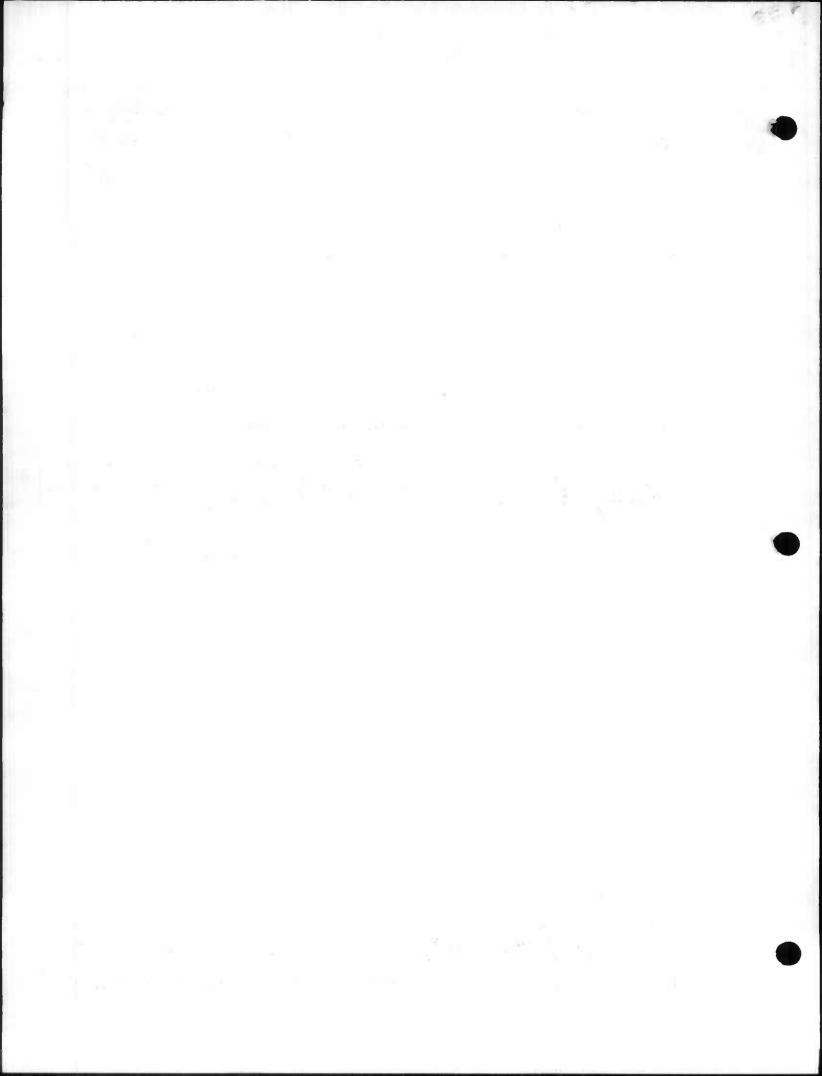
Division

Baltimore, Maryland 21215-0020



State of Maryland / Department of Health and Mental Hygiene 97 27190

| | | | | | | Cer | tificate of | Death | | Re | g. No. | | | |
|---------------------|--|----------------|---|---|-------------------------------|-------------------|---|----------------|-----------------|---|--------------------------|-------------|--|-------------------|
| | Share to | | 1. Decedant's Nama (First, Middla, La | ast) | | | | | | 2. Data of Death | h Day | Yaar | 3. Time | a of Death |
| | Physic /Medi | | Lai Th | i Le | | | | | | August | | | 8:4 | 5 AM. |
| 5 | Exami | | 4a. Facility Nama (If not Institution, gire | | | | | 4b. City, To | wn, or Lo | cation of Death | 4c. Count | y of Death | | |
| | | | 4521 East West H | | | | | Beth | | | - | gomer | ry | |
| | Funeral Director | | | 1 M 2 M E | (In yrs. last bii | rthday) Yrs. | If Undar 1 Yaa Months Days | | 24 Hrs. Min. | 8. Data of Birth (Month, Day, June 6, | Year) 1937 | | placa (Sta intry) bodia | te or Foreign |
| | yland | | 10a. Sfafa 10b. County | | 10c. City, Tow | n or Lo | cation | | | | | | 10d. Inside | City Limits |
| | Mar a-f st | ctor | Maryland Montgom | ery | Bethe | sda | | | | | | | 1 🗆 Y | as 2 No |
| | or 28 | Director | 10e. Street and Number | _ | | | 10f. Zip Code | | | 10 | g. Citizen of | What Cou | intry? | |
| | ath w | | 4521 East West H | | | 1 | 208 | | | | Viet | | | |
| 20 | a within 72 hours after death with the Maryland ilena. Then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at | by Funeral | 11. Marital Status 1 □ Nevar Married 2 ☒ Married 3 □ Widowed 4 □ Divorcad | 12. Was Dacedant E Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva | | | Vas Decedant of Yas, specify Cu □ Yas 2☑ No | | | ecify Yas or No- Rican, atc.) | | ack, Whita, | | |
| 9 | tural | | 15. Decedant's E | Yaar or Datas: | 169 | Deced | ant's Usual Occu | ination | _ | | 16b. Kind of B | | sian | |
| Maryland 21215-0020 | within 72 ena. than *nat | Completed | (Specify only highast gra Elementary/Secondary (0-12) | ada complated) College (1-4or 5- | | (Giva I | kind of work done O NOT usa retir | a during mos | t of worki | ng | Cigare | | idustry | |
| 121 | e filed with Il Hygiena. other than | S | 8 | | Fa | cto | ry Worke | 7 | | | Manufa | | lng | |
| and | ed at b | Be | 17. Fathar's Nama (First, Middla, Last |) | | | | | | (First, Middle, N | | na) | | |
| Z | d 2 should be ith and Mental 7 is marked or treumatic eve | ² | Hien Van Le 19a. Informant's Name/Relationship | Trans Briefl | 406 | Mailin | n Address (Char | | | Thi Nguy A Route Number, | | Chata 7 | in Contai | |
| | | | Minh Hoang Le/Hus | | | | | | | 1, Beth | - | | | |
| re, | es 1 and 2 of Haalth I Itam 27 It r other tre | | 20a. Mathod of Disposition | Danu | | | | | | | 20c. Location | | 20814 own, Stata | |
| 9 | on of or or or or or or or or or | | 1 ☐ Burlal 2 ☑ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Othar (Special | | Monto | ry, craπ ∩me r | sition (Nama of natory or othar pl cy Crema | torium | 21, | 1997 | Rathac | da N | farul / | and |
| Baltimore, | permit. Pages Department of I important: If its any injury or of | | 21. Signafus of Funeral Service Lige | | Hones | 22 | Name and Add | ress of Facili | ty T | | Bethes ,B | ethes | sda-C | hevy |
| m | Depariment important | | I Kall to | mb M | 00198 | 7. | 557 Wisc | onsin | Aver | Tuneral nue 20814- | Home/ | Chas | se, I | nc. |
| | | | 23a. Part 1. Enter the disease, or corr | plications that caused | tha daath. Do | not ante | etnesda, ar fha moda of dy | Mary, | cardiac o | 20814— or raspiratory arre | 3501 est, | | Approxim | nafa |
| | Physician | | shock, or heart Milure. List only | one cause on each line | а. | | | | | | | 1 | Interval I Onsat ar | nd Death |
| 7 | /Medical Examiner | | Immediata Causa (Final disaasa or condition | Metastat | tic Non | Sma | all Cell | Carc | inoma | of Rig | ht Lun | g 2 | 20 mor | nths |
| | Examine | | rasulting In death) | ۵. | Due to (or as a | conseq | uance of): | | | | | | | |
| - | pe is | nine | | b | | | | | | | | | | |
| | axecut n and al-tran | Examiner | Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury | | Due to (or as a | consequ | uenca of): | | | | | | | |
| 68760, | sicial e buri | edical | triat initiated events | C | oua to (or as a | CORSON | lance of). | | | | | | | |
| x 68 | eath certificate be asscuted attending physician and for use as the burial-transit | Medi | rasulting in death) Last | - | | 50110040 | -21100 017. | | | | | | | |
| Bo | death co | lan | | d | | | | | | | | 1 | | |
| Ö | the d | Physician | Part II. Other significant conditions of | ontributing to death but | t not rasulting i | n tha un | darlying causa g | ivan In Part I | l. | 23b. Did to | bacco use co | ontributa t | o the csu | se of death? |
| ۵. | that the | | | | | | | | | 1 □ Ye | 8 2□No | 3 ☐ Pro | obably 4 | Unknown |
| Records | S 50 | d by | | | | | | | | 24a. Was ar | autopsy | 24b. W | /ara autop: | sy findings |
| S | - U 0 | lete | | | | | | | | perform | red? | CO | vailable pri omplation of death? | or fo of causa |
| Re | Tha law ata has b page 2 s | Completed | | | | | | | | 4 🗆 Va | s 2 🖾 No | | ☐ Yas 2 | NO NO |
| Vital | | 60 | 25. Was casa referred to medical | | | | | 26 Place | of Death | (Check only one | | | □ T#3 2 | M 140 |
| | 5 00 | o O | examiner? 1 ☐ Yas 2 ☑ No | Hospital: | nt 2 ER/Ou | utpatient | 3 DOA 0 | thar: | | na 5 🖸 Resida | | her (Speci | ifv) | |
| ٥٥ | F F E | T :U | 27. Mannar of Death | 28a. Date of Injury (Month, Day | | Tima of njury | 28c. Inji | | | 28d. Describe ho | | 1-7- | 77 | |
| Sion | Attending is death. ector: After by the funer | atio | 1 Natural 5 Pending 2 Accidant invastigatio | n | , out, | rigury | | Yas 2 | No | | | | | |
| Division | in the | Certification: | 3 Sulcida 6 Could not b 4 Homicide determined | 28a. Place of Injurbuilding, atc. | ry - At home, fa (Specify) | ırm, stre | eat, factory, office | | 1 | 28f. Location (Str City or Town | reat and Num , Stata) | ber or Rur | al Routa N | um <i>ber</i> , |
| _ | To the Hospital or Attend within 24 hours aftar deatl To the Funeral Director: completaly filled in by the | edical C | (Check only 2 Madical Exar | nysician: To the best of niner: On the basis of a | axamination an | , daath | occurred at the testigation, in my | lme, date an | id place, a | and due to the ca | use(s) and m | annar as i | stated. | se(s) |
| | within 2 To the complex | Med | one) 29b Square and title of cartifiar | and mannar state | ed. | | | nsa numbar | | | d. Data signa | | | |
| | F F F 8 | 10.20 | | Smal 1 | 111 | | X | 1720 | 1 | V | | 10 | 100 | |
| , | 1 | | James 4. K | way (| uu) | /T * | Briat\ | UIN | <i>\</i> | 4 | 12men | 10 | (11) | t |
| | | | A RID | MINIMA CAUSA OT GA | ath (Item 23a) | Гуре | AVEN S. | dina | Poli | VE ROCK | DILE 1 | LARY | Lacin | 2025 |
| | Sta | te | 31. Date filed (Month Day Year) | 32. Registra | 's Signature | 9-6 | Carried Color | CA COL | | 1 | -1-6,1 | 14-11 | CIND. | |
| | Registr | - | AUG 26 | 1991 Juli | a Davidson | 1-12 | nolette | | | | | | | |



State of Maryland / Department of Health and Mental Hygiene 97 27 191

| | | | | | Ce | rtificate | e of | Death | | | Reg. No. | | 61121 |
|---------------------------------------|----------------|--|---------------------------------------|---------------|------------------------------|----------------------------|-------------------|-----------------|---|---------------------------------|--------------------|--------------|--|
| Dhyalais | _ | 1. Decedent's Name (First, Middle, La | ist) | | | | | | | 2. Date of Dea | ath | Vana | 3. Time of Death |
| Physicia /Medic | | JAMES | т | LAZ | ARUS | | | | | AUG. | 23,] | L997 | 7:00 A |
| Examin | | 4a. Facility Name (If not institution, give | re street and number) | | | | | 4b. City, To | wn, or Lo | cation of Death | 4c. County | of Death | |
| | | 13207 VALL | EY DR. | | | | | ROCK | VIL | LE | MON | TGOM | MERY |
| Funeral | | Social Security Number 6. S | Sex 7. Ag | | st birthday) | If Undar Months | 1 Yaar Days | If Under 2 | 24 Hrs. | R Date of Birt | h | | laca (State or Foreign |
| Director | | 214-02-1313 | IQM ZUF | 82 | Yrs. | | | | 14 | MARCH . | Year) 19,1915 | IN | DIA |
| 3 | | Usual Residence of Decedent 10a. Stata 10b. County | | 10a City | Town or Lo | nation | | | | | | | |
| show | _ | | | Toc. City, | , TOWN OF LC | cation | | | | | | 10 | Od. fnside City Limits |
| Sa-f | Director | MD. MONTGO | MERY | | R | OCKVI | - | | | | | | 1 XYes 2 No |
| Den | i | 10e. Street and Number | | | | 10f. Zip | Code | | | | 10g. Citizen of \ | What Coun | lry? |
| "natural", or items 23s or 28s-f show | ra Ta | 13207 VALLEY 1 | DR. | | | | 208 | | | | | NDIA | |
| E a | Funeral | 11. Marital Status | 12. Was Decedent I Armed Forces? | Ever in U,S | 13. | Was Deced | ent of H | lispanic Orig | in? (Spe | cify Yes or No- Ricen, etc.) | 14. Rac | e - Amarica | |
| 6 | | 1 Naver Marriad 2 Married | 1 Yes 2 1 | No | i | 1 □ Yas 2 | | Specify: | | | Specify | | |
| E E | d by | 3 Widowed 4 Divorced | Year or Dates: | | | | | | | | Opecin | AS: | IAN |
| Medical | Completed | 15. Decedent's Ed (Specify only highest gra | ducation ide completed) | | (Give | dent's Usue kind of won | k done i | during most | of worki | ng | 18b. Kind of Bi | usiness/Ind | lustry |
| a a | du l | Elementary/Secondary (0-12) | College (1-4or 5 | | | DO NOT us | | | | | | | |
| 14, 17 | | 47 Falbada Nama (Gast Mildle Lass | 2 | | DIVIS | IONAL | COV | | | | INDIAN | | WAYS, IND |
| ked othe ic event, | Be | 17. Father's Name (First, Middle, Last, | | | | | | 18. Mother | r's Name | (First, Middle, | Maiden Sumen | 10) | |
| a tic | ဥ | JAMES | LAZAR | US | | | | | ESI | HER | JAM | ES | |
| traumatic | | 19a. Informant'a Name/Relationship (| | | 19b. Mailir | ng Address | (Street | and Numbe | r or Aura | I Route Numbe | r, City or Town, | State, Zip | Code) |
| d by | | PREMI THILAGAR/ | DAUGHTER | | 13532 | | | HILL | WAY | , NORTH | I POTOMA | AC, MI | 20878 |
| - 50 | | 20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ | Bomoval from State | | nce of Dispo metery, crer | | | :e) | | Date | 20c. Location - | City or Tox | wn, State |
| | | 4 Donation 5 Other (Specif | | PAR | KLAWN | MEM. | PAF | RK. | 8 | 3/29/97 | ROCKVI | TILE | MD |
| any injury once. | | 21. Signature of Funeral Services Licen | 1800 | | | . Name and | | | | 1-21-21 | 1100111 | ويستن | 10. |
| amy ir | | MAMChan | Verent- | Maa | 007 0 | r a Santa | 00 7 | 77 FD TYTO A | T | Ama n | | | PRING, MD. |
| STREET, STREET, | - | 23a. Part 1. Enter the disease, or com | plications that caused | the death | Do not ent | er the mode | not dyla | UNERA | L HC | MES, P. A | A., SILV | ER SI | |
| alaian | | 23a. Part1. Enter the disease, or com shock, or heart feilure. List only | one cause on each lin | 10. | 00 1101 0111 | or are mode | or dyni | g, such as t | ALI UIOC O | i respiretory en | 1831, | | Approximate Interval Between Onset and Death |
| dical | 1 | Immediete Cause (Final | | | | | | | | | | | Onsot and Death |
| niner | | disaase or condition resulting in death) | a. PNE | UMON: | IA | | | _ | | | | | 1 WEEK |
| | ē | | | | as a conseq | juence of): | | | | | | | |
| nsit . | 틽 | | b. DIAI | BETE | S | | | | | | | | YRS. |
| -tra | Examiner | Sequentially list conditions, if any, leading to Immediate ceuse. Enter Undarlying | | Due to (or a | as a conseq | uence of): | | | | | | | |
| | | Cause (Disease or Injury | c. CONC | GEST: | IVE H | EART | FA | ILUR | E | | | i | YRS. |
| the | edical | that initiated events resulting in death) Last | C | Dua to (or a | as a conseq | uence of): | | | | | | | |
| | Ž. | | d | | | | | | | | | | |
| foru | lan | | | | | | | | | | | 1 | |
| peq | Physician | Part II. Other significant conditions co | ontributing to death bu | it not rasult | ing in the ur | ndarlying ca | use giv | an in Part i. | | 23b. Did to | obacco use co | ntribute to | the cause of death? |
| | | ANASARCA | | | | | | | | 1 □ Y | es 2 No | 3 Prob | ably 4 Unknow |
| L a | ò | | | | | | | | | | | | |
| should | 36 | | | | | | | | | 24a. Was a perfor | in eutopsy med? | ava | re autopsy findings ilable prior to |
| 90.28 | Completed | | | | | | | | | | | of d | pletion of cause eath? |
| page | 0 | | | | | | | | | 1 □ Y | es 2 No | 1 🗆 | Yes 2□ No |
| | _ | 25. Was cese referred to medicel exeminer? | | | | | | 28. Place | of Death | (Check only or | ne) | | |
| Ö | 0 | 1 Yes 2 No | Hospital: 1 Inpatlar | nt 2 E | R/Outpatien | t 3□ DOA | Othe | er: 4 Nur | sing Hon | na 5 🔀 Reside | ence 8 Oth | ar (Specify) |) |
| | | 27. Manner of Death | 28a. Dete of Injury (Month, Day | y 2 | 8b. Time of | 28 | c. injury Work | at | 2 | 8d. Describe h | ow Injury oocurr | ed | |
| in by the fune | 200 | 14∑Natural 5 ☐ Pending 2 ☐ Accident Investigation | | rour) | injury | М | | Yes 2□N | 0 | | | | |
| Dy 42 | Certification: | 3 ☐ Suicida 6 ☐ Could not be determined | 28e. Place of Inju | ry - At hom | e, farm, stre | et, factory, | office | | 2 | | treet and Numb | er or Aural | Route Number, |
| ë j | 9 | 4 🗆 Horniode | building, etc. | . (Specify) | | | | | | City or Town | n, State) | | |
| # | | 29e. Certifier 1X Certifying Phy | sician: To the best of | f my knowle | edge, death | occurred at | the tim | e, date and | plece, e | nd due to the c | ause(a) and me | nner as sta | ited. |
| completaly filled | a Cal | (Check only 2 Medical Exam | iner: On the basis of and manner stat | examinatio | n and/or Inv | estigation, i | in my op | oinion, death | occurre | d at the time, d | ate and place, | and due to | the ceuse(s) |
| completely filled in by | - | 29b. Signatura and title of certifier | , | | | 29c. | License | nu <i>m</i> ber | *************************************** | 2 | 9d. Date signed | d (Month, D | lay, Year) |
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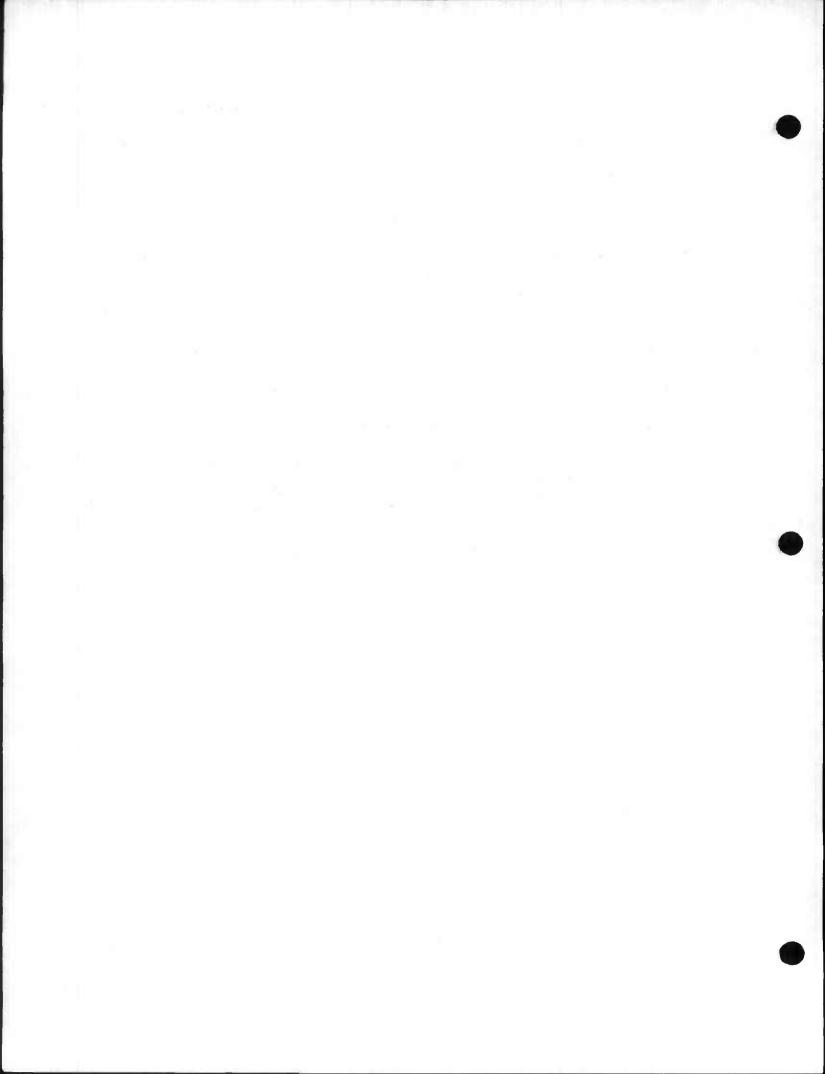
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| | ath with the Maryle 23s or 28s-f show | Funeral Director | 10e. Street and Number 15310 Beaverbro 1530 PEAVERSHOOK | %.Court #13 | J | 10f. Zip Co | | | 10g. Citizen of USA | What Coun | itry? |
| 020 | urs efter deat al', or items : Examiner on | by | 11. Marital Status 1 Navar Married 2 Marriad 3 Widowad 4 Divorcad | 12. Was Decedant Evar Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yeer or Datas: | in U,S. | 3. Was Decedant If Yas, specify | of Hispanic Orlgin? (S Cuban, Maxican, Puer No <i>Spacify</i> : | pecify Yes or Note Rican, atc.) | o- 14. Re Bis | ce - Amaric ack, White, fy: WI | |
| Maryland 21215-0020 | 2 should be filed within 72 hours efter death with the Maryland and Mental Hygiene. Is marked other than "natural", or itema 23a or 28a-f show surratic event, the Medical Examinational be notified at | Be Completed | 15. Decedent's Ed (Specify only highest gra- Elementery/Secondary (0-12) 1 2 | ucation da com <i>plated)</i> College (1-4or 5+) | | ocedant's Usual O ive kind of work d e. DO NOT usa n | ocupation lone during most of wo etired) | rking | 16b. Kind of B | | dustry |
| /land | d 2 should be filed th end Mental Hygi 7 Is marked other traumatic event, I | To Be C | 17. Father's Nema (First, Middla, Last) CHARLES SUPOWITZ | | | | 18. Mother's Nat ANNA KAP | | , Maiden Suma | ma) | |
| (au) | 2 sho end h is me | | 19a. Informant's Name/Relationship (7 | | 19b. M | ailing Address (S | treet and Numbar or Ru | ural Routa Numb | er, City or Town | , Stata, Zip | Coda) |
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| Baltimore, | permit. Page Department of Important: If any Injury or once. | | 21. Signature of Funaral Sarvica Licen | 1 Ston | 2 | 22. Neme end ADANZANSK | ddrass of Facility Y-GOLDBERG KVILLE PIK | MEMORIA E, ROCK | AL CHAPI | ELS, 1 | INC. |
| | Physician /Medical Examiner | er | 23a. Part1. Enter the disease, or comp shock, or heart fallura. List only of Immediate Causa (Final disease or condition resulting in death) | e. HEPATIC FA | ILURE to (or es e con | | oying, such as cardier | c or respiratory a | arrest, | 1 | Approximeta Intarval Between Onsat end Death |
| x 68760, | requires that the death certificete be associated and signed by the ettending physician and hould be detached for use as the burish-transit | Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last | c. BREAST CAN | to (or es e con | | | | | | |
| Box | eath cert ettending | Physician/M | | | | | | | | | |
| P.O. | es that the de igned by the e be detached | hysi | Part II. Other significant conditions co | ntributing to death but no | t rasulting in th | a undarlying caus | a givan in Part I. | | tobacco usa co | | the cause of death? |
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| tal | T age | | PANCYTOPENIA 25. Wes casa referred to medical | | | | | | Yas 2 No | 10 | Yas 2 No |
| f Vi | Physician: this certific ral director, | To Be | axaminer? | Hospital: | 2 ER/Outpa | tient 3 DOA | 26. Place of Dec Other: 4 ☐ Nursing H | | one) idanca 8 □Ot | har (Specifi | 1) |
| Division of Vital Records, | fe fe | Certification: | 27. Menner of Deeth 1 ☑ Natural 5 ☐ Panding 2 ☐ Accident investigation 3 ☐ Sulcida 6 ☐ Could not be | 28e. Deta of Injury (Month, Day Yea | 28b. Timi Injur | a of 28c. | Injury et Work? 1 Yas 2 No | 28d. Describe | how injury occu | rred | |
| Div | after after Direct of in by | ertif | 4 Homicide datarmined | 28e. Placa of Injury - building, atc. (Sp | At home, ferm, pecify) | straat, factory, of | lice | City or To | (Street and Num wn, State) | ber or Hura | l Houta Number, |
| | To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fi | edicai C | 29a. Cartifier (Check only one) 1 Cartifying Phy 2 Medical Exam | elcien: To the best of my lner: On the bests of exer and mannar stated. | knowledga, de nination and/or | eath occurred et the invastigation, in a | na time, dete end plece my opinion, daath occu | , end dua to tha irred et the time, | causa(s) and m dete end place, | enner as st and dua to | eted. the cause(s) |
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| | | | 30. Nema and addrass of person who c | omplated cause of death | (Itam 23a) (Typ | pe, Print) MEDICAL | CENTER DRI | VE, #22 | 1, ROCKV | /ILLE, | MD 20850 |
| | Sta Registr | | 31. Data filed (Mont/AUG 2"6 1 | 32. Registrar's S | avidson- | Randella | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 27193

| Jusual Residence of Decedent Oa. State Job. County Maryland Montgom Oe. Street and Number 309 Windsor Street 1. Maritel Stetus 1 Never Married 3 Widowed 4 Divorced 15. Decedent's Expecify only highest grade Elementary/Secondary (0-12) 8 7. Father's Name (First, Middle, Last, William Lyles 19a. Informant's Name/Relationship (17 Thomas L. Lyles Oe. Method of Disposition 11 Burial 2 Cremation 3 Carried 4 Donation 5 Other (Specification) 11 Significant of Euneral Service bicer 23a. Part 1. Enter the disease, or comshock, or heart failure. List only | Seve street and number) Pet Sex 12 M 2 F 12 Was Decedent Eve Armed Forces? 1 M Yes 2 No If Yes, Give Year or Dates: Un Iducation ade completed) College (1-4or 5+) (Type, Print) | lor in U,S. 1: known 16a. Der (Gille Rece) 19b. Ma 309 T 20b. Place of Discemetery, c Gate of | Months Da Location Proceeding of the first | Silver S sar If Under 24 Hrs ys Hours Min 20910 of Hispenic Origin? (S cuban, Mexicen, Puer No Specify: cupation me during most of wo tired) 18. Mother's Na Nora set and Number or R Street Si place) Cemetery | Location of Death Pring 8. Date of Birth (Month, Day, July 17. Specify Yes or Noto Rican, etc.) Mrking me (First, Middle, Manager, Manager, Middle, Manager, | Day 24, 199 4c. County Montg. Year) 1901 1901 14. Race Blace Specify. 16b. Kind of Bu Federal faiden Sumami | of Death omery 9. Birthplace (State or Incountry) South Carol 10d. Inside City 1 |
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| 23a. Part1. Enter the disease, or com shock, or heart failure. List only | trond | | 22. Name and Ad | | 8/28/97 | 341 | 0 1 21 |
| 23a. Part1. Enter the disease, or com shock, or heart failure. List only | Frond | | | | | oriver ! | Spring, Mary |
| | applications that caused the cone cause on each line. | | | | | ** | ~ |
| | applications that caused the one cause on each line. | | | J. Collins | | | |
| | one cause on each line. | death Do not s | 500 Unive | ersity Blv | c or respiratory arm | Lver Sp | ring, MD 209 |
| | | | | ayg, 00000 0000 | o on toophatory and | ,01, | Interval Betwe Onset and De |
| | | | · · | | | | Orisot and Do |
| mmediate Cause (Final disease or condition | . Cerebr | o vaso | cular | avrid | enl | | 1 das |
| esulting in death) | a. Cerebr b. Ceeb | e to (or as a cons | sequence of): | | | | |
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| Sequentially list conditions | | e to (or as a cons | | -00/1 | | | |
| Sequentially list conditions, eny, leading to immediate euse. Enter Underlying cause (Disease or injury | | | | | | | |
| Cause (Disease or injury that initiated events | C | | | | | | |
| esulting in death) Last | Due | to (or as a cons | sequence of): | | | | |
| L | d | | | | | | 1 |
| | | | | | | | |
| art II. Other significant conditions o | contributing to death but no | ot resulting In the | e underlying cause | given in Part I. | 23b. Did to | bacco use con | ntributa to the cause of |
| 1/4 | | | | | 1 🗆 Ye | s 2 No | 3 Probably 4 Vur |
| Nohe | | | | | | | _ , \ |
| | | | | | 24a. Was a | autopsy | 24b. Were autopsy find |
| | | | | | perform | ned? | avaliable prior to completion of ceu |
| | | | | | | | of death? |
| | | | | | 1 □ Ye | s 2 No | 1 ☐ Yes 2 ☐ N |
| 5. Was case referred to medicel | | | | 26. Place of De | ath (Check only on | 9) | |
| | Hospital: | 2 □ EB/Outpet | tient 3 DOA | Other | | | er (Specify) |
| - W | | 1 | | | | | |
| 1 Naturel 5 ☐ Pending | (Month, Day Ye | | y V | Nork? | | , . , | |
| 2 D Accident | | | | | | | |
| 4 ☐ Homicide determined | 28a. Place of injury - | - At home, farm, Specify) | street, factory, offi | ce | | | er or Rural Route Numbe |
| | | | | | | | |
| 9a. Certifier (Certifying Ph | nyalcian: To the best of m | y knowledge, de | ath occurred at the | time, date and place | e, and due to the ca | use(s) and mai | nner as stated. |
| (Check only 2 Madical Examone) | ninar: On the basis of exa and manner stated. | amination and/or | investigation, in m | y opinion, death occi | urred at the time, de | ite and place, a | and due to the cause(s) |
| Ti | | | 29c. Lice | ense number | 29 | d. Date signed | d (Month, Day, Year) |
| 9b. Signeture and title of certifier | | | | | | | |
| 1 | | 1 . | A | UX1245 | | 8/2 | 6/97 |
| · George | | MD | | | | | |
| · George | | MD (Item 23a) (Typ | | | | | |
| 7 | 5. Was case referred to medicel examiner? 1 | art II. Other algnificant conditions contributing to death but in | art II. Other significant conditions contributing to death but not resulting in the North Conditions contributing to death but not resulting in the North Conditions of the No | art II. Other significant conditions contributing to death but not resulting in the underlying cause Notice | art II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. | art II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | 23b. Did tobacco use constituting to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No 5. Was case referred to medicel examiner? 1 Yes 2 No 6. Place of Death (Check only one) 1 Naturel Naturel Naturel North, Day Year) 2 Accident Investigation Suicide determined 2 Sea. Date of Injury At home, farm, street, factory, office 2 Sea. Certifier (Check only one) 28a. Place of Injury - At home, farm, street, factory, office 2 Sea. Certifier (Check only one) 2 Sea. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marrier stated. 2 Sea. Signeture and title of certifier 2 Sea. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marrier stated. 2 Sea. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and marrier stated. 2 Sea. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and marrier stated. 2 Sea. Date of Injury - At home, farm, street, factory, office of the time, date and place, and due to the cause(s) and marrier stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marrier stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marrier stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marrier stated. |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item:11 per Informant G-769 3/22/99 reb Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth AUGUS) **Physician** DUVUan 1935 /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 29, 1 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 20 F Yrs 220-92-8209 Director 70 Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits than "natural", or items 23s or 28s-f show the Wedical Examiner must be notified at 1 ☐ Yes 2 🖾 No Director Maryland Montgomery Gaithersburg 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 16452 Tomahawk Drive 20878 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0020 þ Specify: Asian **\$€**Widewed 4 □ Divorcad Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Domestic other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Tsing-Soon Cheng .Ten Wil 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16452 Tomahawk Dr., Gaithersburg, Md. 20878 Yueh Li 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 8-23-97 Rockville, Maryland Parklawn Memorial Park Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, Md. 20904 subsed the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, **Physician** /Medicai Immediate Cause (Final disease or condition resulting in death) HEPATIC FAILUPE Examine CIRPHOSIS Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury thal Initiated events resulting in death) Lest Box 68760. Physician/Medical for usa Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? EXSTRIC CARCINOUNA 1 ☐ Yes 2 ☐ No 3 ☐ Probabty 4 ☐ Unknown Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes an autopsy page 2 certificata 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 1 ☐ Yes 2X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred After in 24 hours after death.
The Funerel Director: After the funerel Director of t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigetion 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) and manner as stated. Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated.

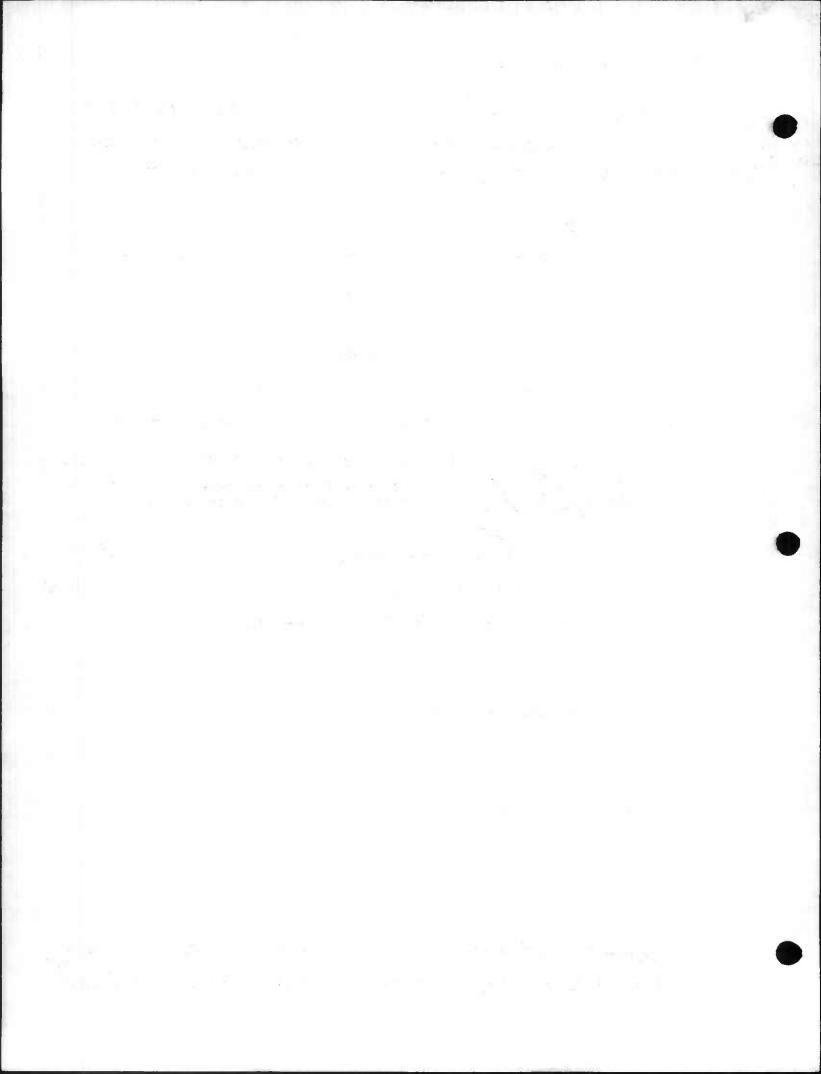
29c. License number

9707-MEDICAL CENTER DRIVE, KOCKVILLE MADE

of death (Item 23a) (Type, Print)

29d. Dete signed (Month, Day, Year)

State Registrar 29b. Signeture and title of certifier



DHMH 16 Rav 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 27 195

| | | | | | | | (| Certifica | te of | Death | | | Reg. No. | | lon f | , , , |
|------------|--|----------------|---|----------------------------|--|---------------------------|--------------|---------------------------------|-----------------|-----------------------------|-------------|------------------|---------------------|-----------------------|-------------|----------------|
| | The same | | 1. Decedent'a Neme (First, M | fiddle, Lasi | t) | 100 | | | | | 1 | 2. Dete of De | ath | ., | 3. Tin | ne of Death |
| | Physic | | Margaret | Reck | line Mi | tchem | | | | | - 1 | Month 08 | 13 10 | Year 997 | 090 | 20 |
| | /Medi Exami | | 4a. Facility Name (If not instit | | | | | | | 4b. City, To | wn, or Lo | cation of Deatl | 7 | y of Deeth | 05 | ,0 |
| 1 | m.K. | | Anne Arur | ndel M | Medical | Cente | ~ | | 1 | Annap | olie | | Anno | Aruno | 3_1 | |
| т | Funeral | | 5. Social Security Number | 6. Se | X | 7. Age (In yrs | | | r 1 Yaa | If Under | 24 Hrs. | 8. Date of Bir | th | 9. Birth | piace (St | ate or Foreign |
| H | Director | | 212 05 5338 Usual Residence of Decedar | | □ M 2∏xF | 88 | Yı | Months | Deys | Hours | Min. | Oct/31 | /1908 | Cou | ylan | _ |
| | yland | | 10a. State 10b. Co | unty | | 10c. C | ity, Town | or Location | | | | | | | Od. Insk | de City Limits |
| | Mar H | to | MD Ann | e Arı | undel | G | len E | Burnie | | | | | | | 1 🗆 | Yes 20 No |
| | r 284 | Director | 10e. Street and Number | | | | | 10f. Zi | p Code | | | | 10g. Citizen of | What Cou | ntry? | |
| | 3a o | 0 | 1021 Fitzall | en Ro | ad | | | 21 | 060 | | | | USA | | | |
| | Jeath Tre 2 | Jer 8 | 11. Maritai Status | | 12. Was Dece | | U,S. | | | Hispanic Ori | gin? (Spe | cify Yas or No | | ce - Americ | can India | n, |
| 21215-0020 | July 2 bours after death with the Maryland jiene. Then "netural", or items 23s or 28s-f show the Madical Expirition must be notified at | by Funeral | 1 ☐ Nevar Married 2 ☐ 3 ☐ Widowed 4 ☐ Divo | | Armed For 1 ☐ Yes If Yes, Give Yaar or Da | No | | If Yes, spe | cify Cul | oan, Maxican | i, Puèrto | Rićan, etc.) | | ick, White, ty: Wh | etc. ite | |
| 2-0 | 2 ho | Completed | 15. Dece | dent'a Edu | cation | | 16a. D | ecedent's Usu | ai Occu | pation | | | 16b. Kind of E | Business/In | dustry | |
| 21 | C 1 61 | pie | (Specify only hi | | College (1- | 4or 5+) | - 9 | Give kind of wife. DO NOT i | ise retin | i <i>aun</i> ng mosi ed) | t of worki | ng | | | | |
| 21 | Mar Share | 000 | 10 | | | | Но | memake: | r | | | | Own Ho | me | | |
| Maryland | should be filed within and Mental Hygiene. marked other than imatic event, the Mental control of the Mental co | Be (| 17. Father's Neme (First, Mid | ldle, Last) | | | | | | 18. Mothe | er's Name | (First, Middle, | Meiden Suma | me) | | |
| la | Void by Wenth | 10 | Benjamin Rec | kline | 2 | | | | | Eliz | zabet | h Floy | đ | | | |
| a | 40 0 0 0 | ľ | 19e. Informant's Name/Relat | ionship (T) | ype, Print) | | 19b. I | Mailing Addres | s (Stree | | | | er, City or Town | , Stete, Ziţ | Code) | |
| | and and and n 27 i | | Loretta Shep | eta | (daught | er) | 1 | 021 Fit | tzal | len Ro | oad. | Glen B | urnie M | D 210 | 60 | |
| ore | of He item | | 20a. Method of Disposition | | | | Place of D | Disposition (Na crematory or | me of | | | Date | 20c. Location | | | е |
| Ĕ | Peg nt: H | | 1 ☐ Burial 2 ☐ Cremat 4 ☐ Donation 5 ☐ Othe | | | Mc Mc | | oly Rec | | | n 8 | 3/18 | Baltim | ore M | D | |
| Baltimore, | permit. Peges 1 and 2 of Department of Health ar important: If itsm 27 is any injury or other traugologe. | | 21. Signeture of Fungral Sen | vice Licens | 99 | | | 22. Name a | nd Addr | ass of Facilit | y | | | | | |
| 8 | 2012 | | ▶ MWlh | elins: | Nagov | w | 7 | Annapo | olis | MD 21 | 401 | | n Servi | ces | | |
| | | | 23a. Pert1. Enter the disease shock, or heart failure. | e, or compi List only o | iications that ca ne cause on ea | used the dea ich line. | th. Do no | t antar tha mo | de of dy | ing, such as | cardiac c | or respiratory a | rrest, | - | | Between |
| | Physician | | | | - | | | | | | | | | | Onset | and Death |
| 1 | /Medical Examiner | - | fmmediete Cause (Final diseasa or condition | 9 | a C | VA | | | | | | | | i | 1 | NK |
| п | Examino | _ | rasulting In death) | | | Due to | (or es a co | nsequence of) | : | | | | | | | |
| - | pe jis | ine | | | h | | | | | | | | | 1 | | |
| | the death certificate be executed by the ettending physician end sched for use as the buriel-Iransit | Examiner | Sequentially list conditions, | | | Due to | or as a co | nsequence of) | | | | | | | | |
| 68760, | be ed ician burie | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury | 2 | C | | | | | | | | | | | |
| 87 | phys the | Medical | that initiated events resulting in death) Last | | | Due to (| or es e co | nsequence of) | : | | | | | | | |
| × | ding p | | | L. | d | | | | | | | | | į | | |
| Bo | eath ce | lan | | | | | | | | | | | | I | | |
| o · | by the e | Physician | Part II. Other significant con- | ditions cor | ntributing to dea | th buf not re | sulting in t | he underlying | cause g | iven in Part I | | 23b. Dld | lobacco use c | ontributa t | o the ca | use of death? |
| 0. | that the ned by detac | | HTN | de | men | tia | | DNeu | (m | mia | _ | 1 🗆 | Yes 2 No | 3 Pro | bably | 45 Unknown |
| S | 8 0 P | by | | - 02 | | 1,00 | 1 | // | | | - | | | 1 | | |
| Records, | v requires been sign should be | Completed | UTI | | | | | | | | | 24a. Wes | an autopsy rmed? | av | ailable p | |
| ec | 2 s | pie | | | | | | | | | | | | of | death? | of cause |
| <u> </u> | 0 - 6 | 200 | | | | | | | | | | 10 | res 2 No | 1.0 | Yes | 2 No |
| Vital | ysician: The s certificate director, pag | Be (| 25. Was case referred to med examiner? | dicat | | | | | | 26. Plece | of Deeth | (Check only | ne) | | | |
| of < | \$ 00 | ျှ | 1 ☐ Yes 2 No | F | lospitel: | patient 2 | ☐ ER/Outp | atienf 3 D | OA O | her: 4 🗆 Nu | rsing Hor | me 5 ☐ Resi | denca 6 □Ot | her (Specia | (y) | |
| 0 | neral | | 27. Manner of Death 1 Natural 5 □ Pe | ndino | 28a. Date o | Injury , Day Year) | 28b. Tin | ne of | 28c. Inju Wo | iry at | 1 | 28d. Describe | how Injury occu | rred | | |
| <u>Ö</u> | Attending ir death. actor: After by the fune | atic | 2 ☐ Accident Inv | estigation | (******* | , = -, | , | М | | Yes 2 🗆 | No | | | | | |
| Division | if or Attend a after death Director: / d in by the f | Certification: | 3 ☐ Suicide 6 ☐ Co 4 ☐ Homicide del | uld not be termined | 28e. Placa e | of Injury - At I | nome, farm | , street, factor | y, office | C. | 1 | 28f. Location (| Street and Num | ber or Run | al Route | Number, |
| | tal or rs afte al Dir led in | Cer | | | | | .,, | | | | | | | | | |
| | To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer | edicai | 29a. Certifier 1 Certi | fying Phys | alctan: To the b | est of my kn | owledge, o | leath occurred | at the t | ime, date an | d place, a | and due to the | cause(s) and m | enner as s | teted. | en(e) |
| | the H hin 24 the Fi | | one) | Can Example | and mann | stated. | ALIUI AITON | mivestigetion | , army | opinion, deal | iii occurri | ou at trie time, | cate end piece | and due t | O THE COL | 50(8) |
| | Vith To T | Σ | 29b. Signature and little of cer | tifier |) /, | 1 | / | | | sa number | 11 | | 29d. Date sign | ed (Month, | Day, Ye | ar) |
| | | | 1 (1/ | M | 1. 11 | | | | I | 1418 | 16 | | 8/ | 13/ | 7 | |
| | | | 30. Name and eddress of per- | son who co | ompleted cause | of death (It | m 23a) (T | ype, Print) | | | | | | - | | -/ |
| | | | Charles u |). P | h= 405 | | AMI | 641 | 4 F | anklin | St. | Ann | 8/ | MD | 21 | 401 |
| | Sta | te | 31. Date filed (Month, Dey, Y | ear) | - 1 | gistrar's Sign | | 7 | | | V 1 | 7 | 1 | _ | | L |
| | | | | - 100 | _ N | 71. 2 | | | | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Day **Physician** Month Ethel P. Mallard August 16, 1997 3:15PM /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice of the Chesapeake Residence Linthicum Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□ M 20 F Days 66 **Director** 259-42-6911 Nov. 16, 1930 Georgia Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? nil. Pages 1 and 2 should be filed within 72 hours after death with tarnent of Health and Mental Hygiene.

or annt: If item 27 is marked other than "natural", or items 23s or 2 millury or other traumatic event, the Medical Example man be made traumatic event, the Medical Example. 8111 Spalding Circle 21144 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever In U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Missionary Church Planning 12+ 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maider: Sumame) James Edward Phillips Nora Pitts 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8111 Spalding Circle Severn, MD 21144 Charles Mallard 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Aug 19 1997 1 Burial 2 Cramation 3 Ramoval from State Clarkesville, GA Clarkesville Mem. Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungal Service Monsee 22 Name and Address of Facility Barranco & Sons Funeral Home 495 Ritchie Hwy. Severna Park, MD 21146 from that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final 6>400 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ğ physician Physician/Medical 8 Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? à 1 Yes 25 No 3 Probably 4 Unknown bengis d be del ğ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 Yes & No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence & Other (Specify) Hos of ce 2 1 Yes 200 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Zirietural 1 ☐ Yes 2 ☐ No To the Hospital or Attends within 24 hours after death To the Funeral Director: A completely filled in by the fi 2 Accident investigation 3 Suicide 6 ☐ Could not be 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide 29e. Certifier Ecritifying Phyalolan: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 30. Name end address of person who completed cause of death (item 23a) (Type, Print) 795 AquahaT N.S. Fleu Bumpaprison Marel and 31. Date filed (Month, Day, Year)

State Registrar

AUG 1 9 1997

32 Registrar's Signature Achie Davido

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month 0.8 Yeer 97 01:30p.m. **JOHN** CARL MULLER /Medical 4e. Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Caroline Nursing Home, Inc. Denton Caroline 5. Social Security Number If Under 1 Yeer | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) **Funeral** Hours 15M 20 F 85 Yrs. Director 217-36-0623 JAN.20,1912 MARYLAND Usuel Residance of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28=4 show any intry or other transmitter overs, 7a shaping Espainise mast be notified at 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD CAROLINE DENTON 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 520 KERR AVENUE 21629 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Yeer or Detes: 14. Rece - American Indian, Bleck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Merried 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐No Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Bueiness/Industry Elementery/Secondery (0-12) Collega (1-4or 5+) FARMER DAIRY FARMING 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nema (First, Middle, Melden Surname) CARL J. D. MULLER MARY ELIZABETH JACOBS 19a. Informent's Neme/Raietionship (Type, Pnint) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) MARY E. MULLER/ WIFE P.O. BOX 101, CORDOVA, MD 21625 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete ¶ Suriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) WOODLAWN MEMORIAL PARK 8-27 EASTON, MD 21. Signature of Funeral Service Cicani 22. Name end Address of Fecility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 200 S. HARRISON ST., EASTON, MD 23a. Pert1. Enter the disease, or complications that gauss the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart feilure. List only one cause on each one. Approximate interval Between Onset and Death Physician 4 days /Medicai Immediete Ceusa (Finel Preumonia diseese or condition resulting in death) Examine Due to (or as e consequence of): sician and burial-transit Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disaase or Injury that initiated evants resulting in death) Last Due to (or es e consequance of) Division of Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably Unknown by 24b. Were autopsy findings evalleble prior to completion of cause of death? 24e. Wes an eutopsy performed? Completed has 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours after death.

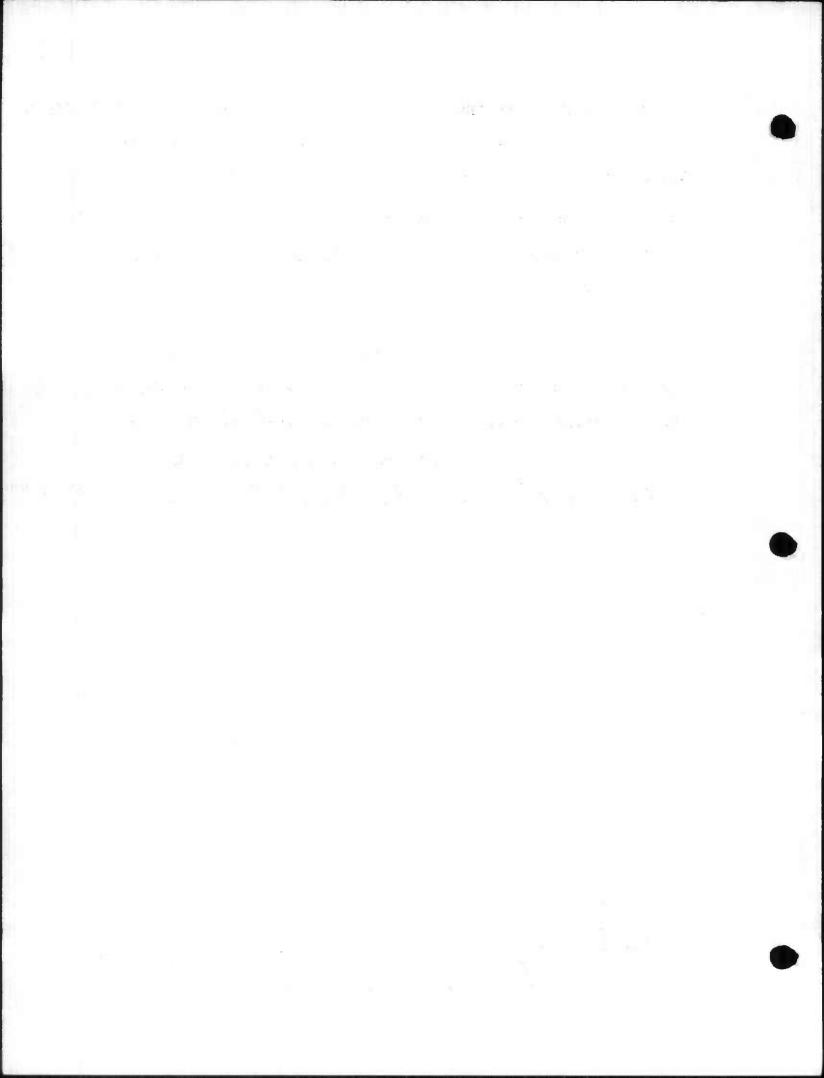
To the Funeral Director: After this certific 25. Wes case raferred to medical axaminer? 8 28. Placa of Deeth (Check only one) 1 Yes 2 No Other: Nursing Home 5 Rasidance 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28d. Describe how injury occurred Certification: 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. injury et Work? 5 Pending Investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 ☐ Accident illed in by the 3 Suicide 6 Could not be determined 28a. Pleca of Injury - At homa, farm, street, fectory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledga, daeth occurred et tha tima, data and plece, end due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, daeth occurred et the time, dete end plece, end due to the cause(s) end menner steted. 29a. Certifier 29b. Signeture and title of pertifier 29d. Date signed (Month, Dey, Year) 30. Name end eddrass of person who completed cause of deeth (Item 23a) (Type, Print) 920 Market St. Jenton 31. Dete filed (Month, Dey, Year) 32. Registrat's Signature

whia Daydson-Randelle

State

Registrar

AUG 27



State of Maryland / Department of Health and Mental Hygiene 97

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| | | 1. Decedent's Name (First, Middle | o, Last) | | | | | 2. Date of Dec | eth | V255 | 3. Time of Death | |
| Physici | | | EDWIN | GILL | MARTIN | V | | August | 24, | 1997 | 5:40 PM | |
| /Medic Examin | | 4a. Facility Name (If not institution | | | | | 4b. City, Town, or | | | y of Death | J.40 II | |
| Exami | ıer | Memorial Ho | The state of the s | | On | | Easton | | | lbot | | |
| | | 5. Social Security Number | | . Age (in yrs. le | | If Undar 1 Yaa | | 8. Data of Birt | | - | lana /Cinta or Familia | |
| Funeral Director | | 213-38-2712 Usual Residence of Decedent | 1□M 2□F | 90 | Yrs. Months Days | | | | v. Year) | 9. Birthplace (Stata or Foreign Country) Maryland | | |
| pund a M | Funeral Director | 10a. State 10b. County | | 10c. City | , Town or Local | tion | | | | 1 | 0d. Inside City Limits | |
| 2 2 10 | | Maryland Talbot | + | St | Michael | le | | | | | 1 ☐ Yes 2 ☐ No | |
| The M 28a-f | | 10e. Street and Number | • | Dt. | MICHAE | 10f. Zip Code | | | 10g. Citizen of | What Cour | Λ | |
| W WITH | | Long Lane 21663 | | | | | | U.S.A. | | | | |
| 3687 78 2 | era | 11. Marital Status | 12. Was Deced | ent Ever in U.S | 5. 13. Wa | | | pecify Yas or No- | | ca - Americ | an Indian, | |
| ours after dears, or items | by | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Siva Yaar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 Yes 2 No Specify: | | | | | | o Rican, etc.) | Black, Whita, etc. Specify: White | | | |
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| should be file nd Mental Hy marked othe umatic event. | Completed | 12 3 Lawyer | | | | | | Tarif Commission | | | | |
| | Be (| 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, | | | | | | | | | | |
| | 10 | Charles Gill Martin Gertrude O | | | | | | ude Owir | vings | | | |
| | | 19e. Informant's Name/Relationsh | nlp (Type, Print) | | 19b. Melling | Address (Stree | at and Number or R | ural Route Numbe | r, City or Town | , State, Zip | Code) | |
| C 75 M to | | Mary M. Petitdel | lange Dau | ghter | 1109 | Harris | on Ave. S | t. Micha | els. M | arvla | nd 21663 | |
| mit. Pages 1 ar partment of Hea portant: if Ihem: y injury or othe GB. | | 20a. Method of Disposition | _ | | ace of Dispositi | ion (Name of | | Date | 20c. Location | | | |
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| | | 4 Donation 5 Other (Specify) Capitol Crematory Aug. 25, 1997 Dover, Delaware 21. Signature of Funarel Servica Licansee 22. Nama and Addrass of Facility | | | | | | | | | | |
| Degrad | | Harrison | Conto | (/ | Ha | arrison | E. Leona | rd Funer | al Hom | е | | |
| | | 312 S. Talbot St. St. Michaels, Maryland 2166 | | | | | | | | | | |
| Discordance | | shock, or heart failure. List only one cause on each line. Interval Between Onsat and Death | | | | | | | | | | |
| Physician /Medicai | | | | | | | | | | | | |
| Examiner | | Immediate Cause (Final disease or condition resulting in death) a. ATHEROSCICIOTIC CARDÍO UNIVERS MENTES | | | | | | | | | | |
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| ertificate be axecuted ling physician and se as the bunal-transit | | Sequentially list conditions, if any, leading to immediate cause. Enter Undartyling Cause (Diseese or Injury that initiated events | | Due to (or as a consequence of): Dua to (or as a consequence of): | | | | | | | | |
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| hat the death | ysic | Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. | | | | | | | obacco use c | ontribute to | the cause of death | |
| at the I by th | by Physician | HiperTersi | 0-1 | Small Bond obsteveran | | | | | 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown | | | |
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| res tha signed d be de | | 11/10/10/31 | | | | | | | | 240. W | | |
| requires the | | - II fficio si | | | | | | 24a. Was perfo | an autopsy med? | av | alleble prior to | |
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| ing Physician: The law n. After this certificate has b funeral director, page 2 s | edical Certification: To Be Completed | 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investig 3 Suicide 6 Could n determine (Check only one) 29b. Signatura and title of certifier | 28a. Date of (Month, ation of be ned 28e. Place of building Physician: To the be examiner: On the bas and manner of the completed cause | Injury Day Year) Injury - At horn, etc. (Specify) est of my known is of examinetic r stated. | 28b. Time of Injury me, farm, street vledge, death or on end/or inves 23e) (Type, Pri | 28c. Inju WW 15c. A factory, office courred at the totigation, in my 29c. Licar | ther: 4 Nursing Funy at ork? Yes 2 No ime, date and place opinion, deeth occur | performance of the control of the co | rened? Yes 2 No No No No No No No No No No | ther (Specifiered) her or Rura her or Rura hanner es si, and due to ad (Month, | alleble prior to mpletion of causa death? Yas 22 No If Route Number, (ated. the cause(s) Day, Year) | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended item #'s 10f and 19a State of Maryland / Department of Health and Mental Hygiene 8/27/97 Carroll Co. p.1.c. Certificate of Death 1 Decedent's Nema /First Middle Last) 2. Dete of Deeth 3. Time Death Month Year **Physician** James Floyd Miller, Sr. 7:00 A.M. 24, 1997 August /Medical 4a. Facility Neme (If not institution, giva street end number) 4b. City, Town, or Location of Daath 4c. County of Daeth Examiner 210 Ridgeville Blvd. Mt. Airy Carroll If Under 1 Year | if Under 24 Hrs. | Months | Days | Hours | Min. | Birthpiece (State or Foreign Country) 5. Sociei Sacurity Number 7. Aga (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Days 1 M 2 F Yrs. 75 Director 214-18-0410 Feb 6, 1922 Woodbine Usuel Residence of Dacedent with the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner mant be notified at 1 Yes 200No Maryland Carrol1 Mount Airy 10a. Street and Number 10f. Zip Code 10g Citizen of What Country? 21771 214-10-0410 United States 210 Ridgeville Blvd. 14. Rece - American Indian, Bleck, White, atc. 12. Wes Decedant Evar in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-if Yas, specify Cuben, Mexicen, Puerto Ricen, etc.) 72 hours efter 1√1 Yes 2 No If Yes, Give Yaer or Dates:WWII 1 Never Merried 2 Merried 1 ☐ Yes 2K No þ Specify: White 3 Widowad 4 □ Divorced 15. Decedent's Education (Specify only highest grada complated) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elamantary/Sacondery (0-12) College (1-4or 5+) 12th Carpenter Construction permit. Pages 1 end 2 should be file Department of Health end Mental Hy Important: If Itam 27 is marked other any Injury or other traumatic event, 2008. 17. Fathar's Name (First, Middle, Last) 18. Mother's Nema (First, Middle, Maiden Sumeme) Mary C. Bloom John Donald Miller 19apingments Name/Raietionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) Pricilla Arnold (Daughter) 5108 Ridge Rd. Mt. Airy MD 21771 altimore, 20b. Piaca of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from Stata 4 ☐ Donetion 5 ☐ Other (Spacify) Pleasant Ridge Cem. Aug 26,1997 Woodbine, MD 22. Nama and Addrass of Facility Burrier-Queen Funeral Home 21. Signatura of Funarei Sarvice Licenses 23e. Pert1. Enter the disease, or complications that caused tha deeth. Do not enter the mode of dying, such as cerdiac or raspiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximete Interval Batween Onsat and Deeth Physician /Medical tmmediata Cause (Final recent myocardial infarction 1 wecks disaase or condition rasulting in daath) Examiner Due to (or es e consequance of): Examiner Sequentielly list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in deeth) Lest Bnd Dua to (or es e consequence of): physician Physician/Medical the Dua to (or as e consequence of): 158 Pert II. Other etgnificent conditions contributing to death but not resulting in the underlying ceusa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown chronic obstructive pulm-nary disease quit smaking 1972 Records, 24b. Were autopsy findings aveilebla prior to completion of ceuse of death? 24a. Wes an eutopsy performed? on Coumadin for a deep venous thrombosis of the left les. 1 Yas 2 No 1 Yas 2 No Division of Vital 25. Was casa raferrad to medical exeminer?

1 Yes 2 No funeral director. 26. Plece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Othar (Specify) ပ this 28e. Deta of injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28d Describe how injury occurred 28c. Injury at Work? 1 Netural 5 Pending death. 1 TYes 2 No investigation 2 Accidant or Attand efter death Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 124 hours e Certifying Physician: To the best of my knowledga, daath occurred at the time, dete end place, end due to tha ceuse(s) and mannar as stated.

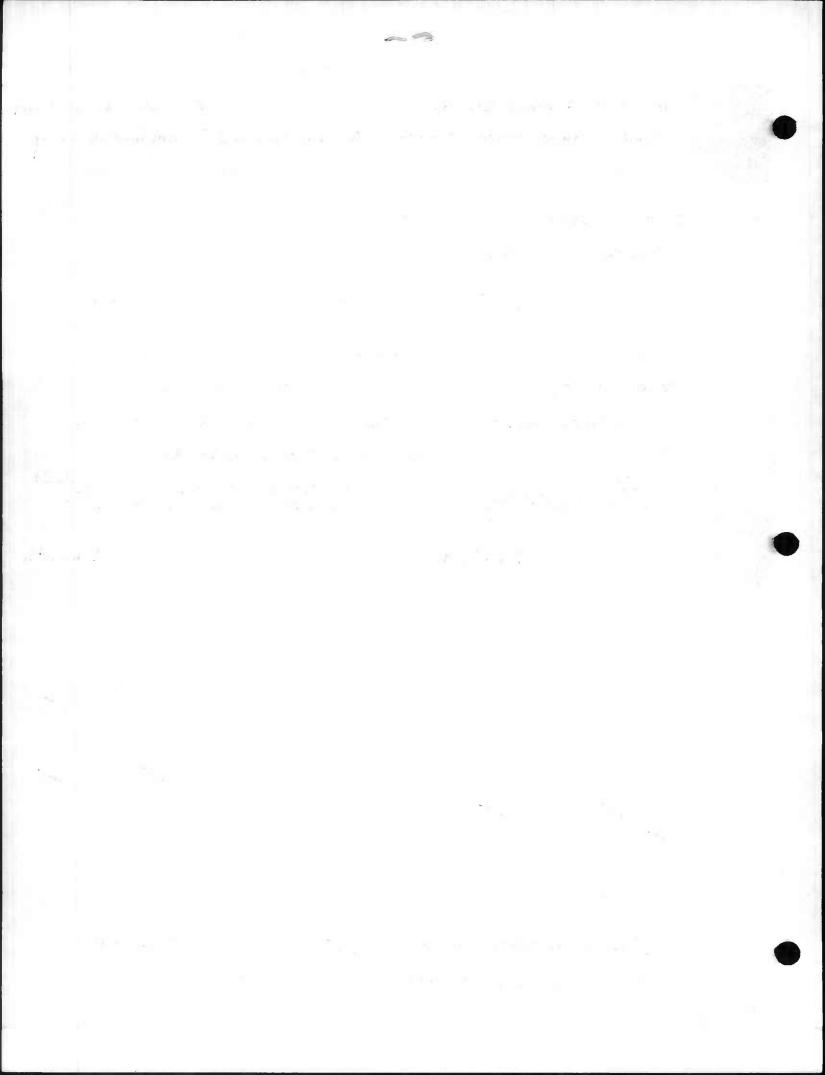
Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at tha time, dete end piece, end due to the ceuse(s) and menner stated. 29e. Certifier To the Hosp within 24 hor To the Fune completely fi edical (Check only one) 29c. Licanse number 29d. Date signed (Month, Day, Year) C. in mi D34406 8/25/97 30. Nama and address of person who complated cause of deeth (Itam 23e) (Type, Print) Richmond P. Allam, MD, 1645 Liberty Rd., Eldersburg, MD 21784 32. Registrar's Signetura 31. Dete filed (Month, Day, Year) State AUG 2 6 1997 Registrar

DHMH 16 Rev 6/95

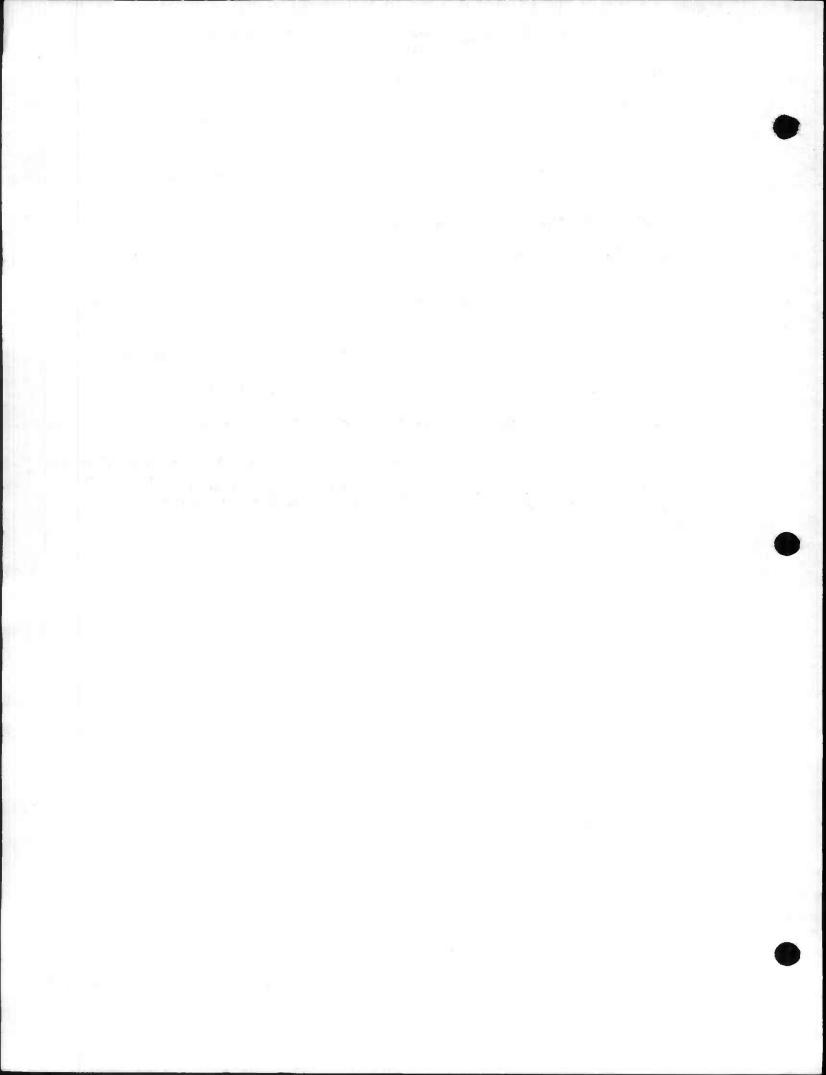
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month 8 **Physician** d:30 bw MICHAELA (NM) MERKL /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE BALTIMORE CITY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 18, 1 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 25 F 73 Director 548-62-6506 1924 Austria Usual Residence of Decedent with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Item 27 is marked other than "natural", or itema 23a or 28a-f show other traumetic event, the Madical Examiner must be notified at 1 Yes 2 No Directo Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 309 North Shamrock Road 21014 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedent Ever In U,S. 14. Race - Amarican Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiena. Important: if Item 27 is marked other than "natural", or item any injury or other traumatic event, it a Medical Example 2008. Black, White, etc. Armed Forces 1 ☐ Yes 2 ☑ No If Yes, Give 1 Navar Marriad 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Yaar or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Franz (UK) Tichy Vernocia (UK) (UK) 19a. Informent's Name/Retationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stefe, Zip Code) Howard U. Merkl - Husband 309 North Shamrock Road, Bel Air, MD 21014 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from Stata Highview Memorial Gardens8/30/97 Fallston, MD 4 ☐ Donation 5 ☐ Other (Specify) 21014 22. Name and Address of Facility Howard K. McComas III Funeral Home, P.A. Aug 50 W. Broadway & Williams St., Bel Air, MD 23a. Part. Enterthe disaase, or complications that cruised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death **Physician** Immadiate Causa (Final disease or condition resulting in death) /Medical Brain tumor 1 month Examiner Due to (or as a consequence of): Examiner physician and the burial-transit certificate be axecuted Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury Due to (or es a consequence of): Box 68760 Physician/Medical that initiated events resulting in deeth) Last Due to (or as a consequence of): 60 950 jo P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? the detached signed by the 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by should I 24e. Was an autopsy performad? 24b. Were autopsy tindings available prior to complation of causa of death? Completed page 2 certificate has 1 Yas 20 No 1 Yas 212 No Attending Physician: 25. Wes case referred to medical examinar? director Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Dey Year) funeral 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No death. Investigation 2 Accident or Attend after death Director: 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 24 hours 8 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and plece, end due to the ceuse(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the To the To the I 29b. Signatura and title of certifiar 29c. Licanse numbar 29d. Date signed (Month, Day, Year) Justian en Haradia mp 8 25 97 D50966 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 344 Drew St. Belto, MD Tushar M. Grovadia MD, 32 Registrar's Signature 31. Date filed (Month, Dey, Year) 1997 AUG 27 Registrar

DHMH 16 Rev 6/95

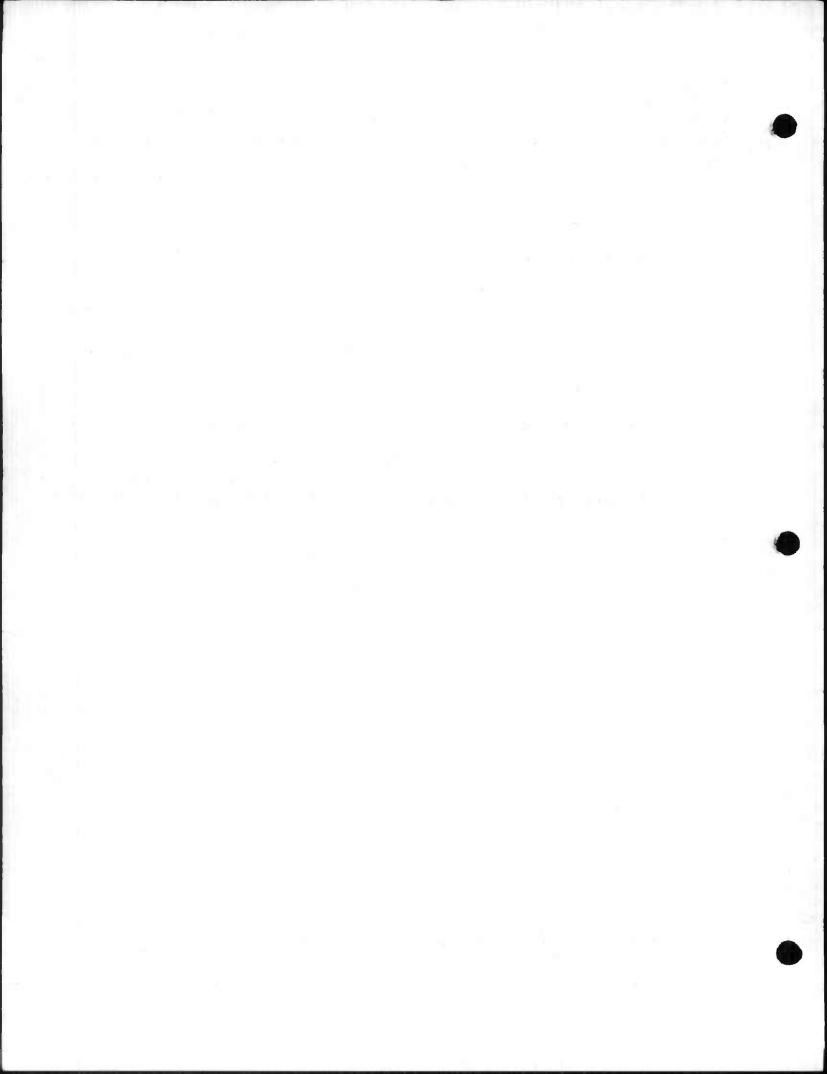


State Registrar me and address of person who completed cause of deeth (item 23e) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene 97 27202

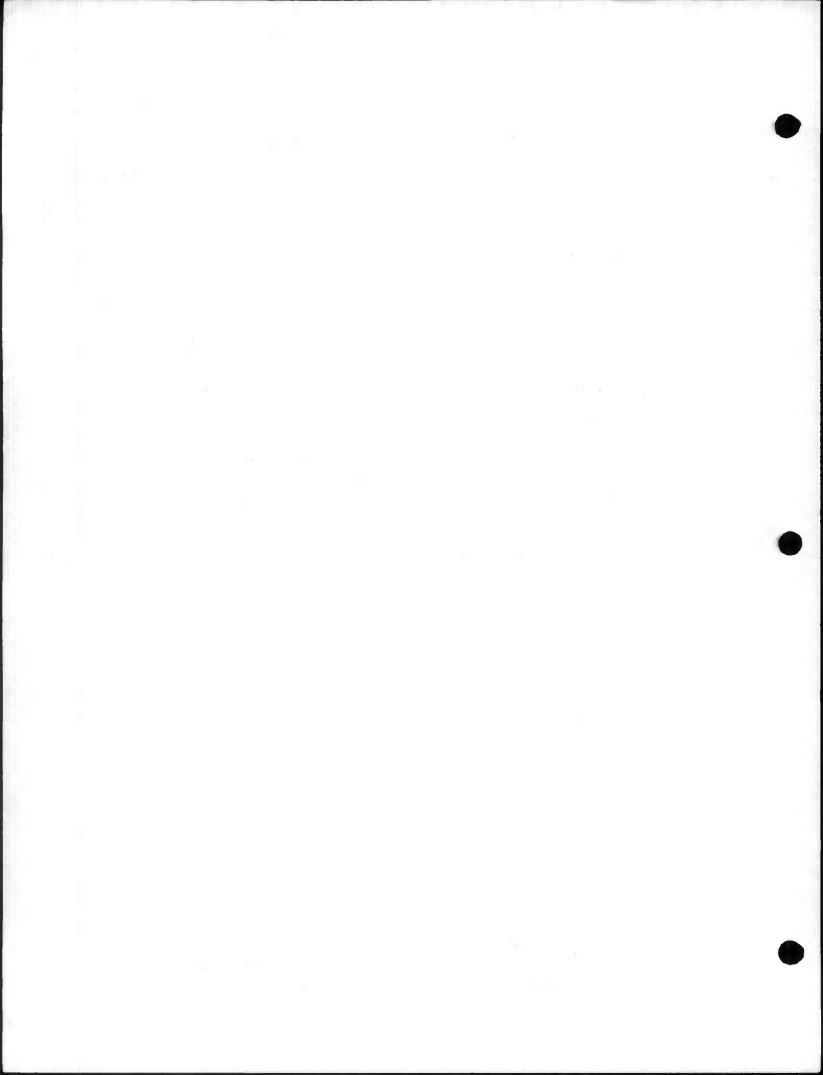
| | | | | | | Ce | rtificate of | f Death | | Reg. N | No. | | |
|-------------|--|----------------|---|--|---------------------------------------|-------------------|--------------------------------------|---|------------------|-----------------------|---------------|------------|--|
| | 1 | | 1. Decedent's Neme (First, Middle, L | ast) | | | | | 2. Dete of I | Death | | 1/25 | 3. Time of Death |
| | Physic /Medi | | Catherine W. Mo | oyer | | | | | AUGUST | | Day | 1997 | 11:55 A |
| | Exami | | 4a. Facility Name (If not institution, gi | ve street end numb | er) | | | 4b. City, Town, or | | - | c. County of | - | |
| | EAUTH! | | Suburban Hospi | al | | | | Bethesd | la | | | tgom | erv |
| | Funeral | | 5. Sociel Security Number 6. | Sex 7. | Age (In yrs. lest b | irthday) | If Under 1 Yea | | | Birth | | | |
| | Director | | 577-05-2079 | 1□M 2\(\)F | 85 | Yrs. | Months Day | s Hours Min | Nov. | Dey, Yea | 911 | | lace (State or Foreign try) ington, DC |
| | ס | | Usual Residence of Decedent | | | - | | | 1100. | 13,1 | . 711 | Masii | Ingcon, De |
| | ylan | | 10a. State 10b. County | | 10c. City, To | wn or Lo | ocetion | | | | | 10 | Od. Inside City Limits |
| | Ma Ma | to | Maryland Montgo | nery | В | ethe | esda | | | | | | 1 □ Yes 2 □ No |
| | r 28 | Director | 10e. Street end Number | | | | 10f. Zip Code | | | 10g. C | Citizen of Wh | at Count | try? |
| | 3ª o | | 4605 Chestnut St | reet | | | 208 | 14 | | Uni | ited S | tate | S |
| | filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or items 23a or 28a-f show ont, the Medical Exerting fixual be notified at | Funeral | 11. Marital Status | 12. Was Decede | ent Ever In U,S. | 13. | Was Decedent of | Hispanic Origin? (ban, Mexican, Pue | Specify Yes or I | | 14. Race | | |
| 0 | or ite | | 1 Never Married 2 Married | Armed Force | | | | | rto Ricen, etc.) | | Black, | White, e | etc. |
| 21215-0020 | urs a | by | 3 Widowed 4 □ Divorced | If Yes, Give Yeer or Date | s: | | 1□ Yes 2X N | Specify: | | | Specify: | W | hite |
| 9 | 2 ho | Completed | 15. Decedent's E | ducation | 166 | a. Dece | dent's Usuel Occ | upation | | 16b. | Kind of Busi | | |
| 218 | hin 7 | ple | (Specify only highest gr | ede completed) College (1-4) | 05.54) | (Give life. | kind of work don DO NOT use retii | e during most of wo | orking | | | | |
| 21 | d wit | E | Elementary/Secondary (0-12) | College (1-4) | OI 34) | Sec | cretary | | | | Ins | uran | ce |
| P | offie other | Be C | 17. Fether'a Name (First, Middle, Las | 1) | | | | 18. Mother's Na | me (First, Midd | le, Meide | en Sumeme; | | |
| a | Menta ked ked ice | To B | Charles F. Wa | aring | | | | Not | Availa | ble | | | |
| Maryland | 2 should be filed within and Mental Hygiene. Is marked other than "reumatic event, the Men | - | 19a. Informent's Name/Relationship | (Type, Print) | 19 | b. Mellir | ng Address (Stree | et end Number or R | lural Route Num | nber, City | or Town, S | tete. Zip | Code) |
| | ges 1 and 2 should be filed within 72 hc tof Health and Mental Hygiene. If item 27 is marked other than "natur or other traumatic event, The Medical | | Norma Moyer / Day | ighter | | | | t Street, | | | | | |
| e, | s 1 and 2 of Health item 27 is | | 20a. Method of Disposition | 8 | 20b. Place | of Dispo | osition (Name of | (ece) Aug. 2 | Dete | | Location - C | | |
| 20 | permit. Pages: Department of H important: If ite eny injury or ot | | 1XXBurial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci | | | | | | | | | | |
| Baltimore, | The state of | | 21. Signature of Funeral Service Lice | | Geor | | | on Cemete | | | lphi, | | |
| Ba | Deparimon important in processions in procession in processions in procession in procession in procession in procession in pro | | 21. Signature of Furieral Service Elect |) 41 | | | | | | | | | eral Home/ |
| | | | Michele 7 | Kulle | M0034 | 8 Be | thesda, | Maryland | 20814 | -350 | 11 W | ISCO | nsin Ave. |
| п | | ш | 23a. Pert1. Enter the disease, or con shock, or heart feilure. List only | plicetions that cause on each | sed the deeth. Do h line. | not ent | er the mode of dy | ring, such es cerdie | c or respiratory | arrest, | | | Approximete interval Between |
| V. | Physician | | | | | | | | | | | | Onset and Death |
| | /Medical Examiner | | Immediate Cause (Finel disease or condition | PU | LMON | MA | Y E | MBOLL | S | | | ì | |
| | Examino | l. | resulting in death) | | Due to (or as a | consec | quence of): | MBOLU VERA | | | | 1 | |
| | 2 4 | ine | _ | , Po | LYCY | 1246 | MIA | VERA | | | | i | |
| | the part | Examiner | Sequentially list conditions, | b | Due to (or as a | consec | quence of): | | | | | | |
| 0, | be execut | | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury | . 4 | YPERT | EN | TION | | | | | 1 | |
| 68760, | erificate be ing physicia e as the bur | Medical | thet initiated events resulting in death) Lest | C | Due to (or as a | | | | | | | 1 | |
| 8 × | office of the party of the part | Med | 111.000 0 111.000 0 1110.000 | | | | | | | | | - | |
| Bô | 0 2 2 | | | d | | | | | | | | 1 | |
| | death we attac ed for u | Physician | Part II. Other significant conditions | contributing to death | h but not resulting | In the u | nderlying ceuse g | iven in Part I. | 23b. Di | d tobacc | o use contr | ibute to | the cause of death? |
| P.0 | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | h | | | | | | | | | 1 | | ably 4 Unknown |
| | 5 5 5 | by F | | | | | | | | | 20110 | | |
| Records, | | | , | | | | | | 24e. We | es en eut | | 24b. Wei | re autopsy findings |
| 8 | > .O 10 | jet | | _ | | | | | per | rformed? | | con | ileble prior to |
| æ | The law ate has b page 2 a | Completed | | | | | | | | | - | | leath? |
| ta | | | 05 W | | | | | _ | 1L | Yes : | 2 12 No | 1 🗆 | Yes 20 No |
| = | Physician: this certific ral director, | Be | 25. Was cese referred to medicel examiner? | Hospital: | / | | | 26. Place of De | | | | | |
| ō | the state of the s | 2 | 1 Yes 2 No 27. Manner of Death | 1 LIII Anpa | | | II 3LI DOA | 4 U Nursing I | Home 5 Re | | | |) |
| Division of | | Certification: | 1 PNaturel 5 ☐ Pending | | Day Year) 286. | Time of Injury | W | | 28d. Describ | e how inj | ury occurred | 1 | |
| S | Attending r death. ector: Atte by the fune | cat | 2 Accident investigation 3 Suicide 6 Could not be | | | | | Yes 2 No | | | | | |
| ≥ | 大石寺に | E | 4 Homicide determined | 200. Flace 01 | Injury - At home, f etc. (Specify) | arm, str | eet, factory, office | | | (Street a own, Ste | | or Rurel | Route Number, |
| | ours a ours a meral D | | | | | | | | | | | | |
| | Hospital 24 hours Funeral etely filled | edicai | 29a. Certifier 1 Cartifying Pl | nysician: To the be miner: On the basis | st of my knowledg | e, death | occurred at the | ime, date end plec | e, and due to th | e ceuse(| s) and mann | ner as sta | ated. |
| | 4640 | | one) | and manner | stated. | 10/01 111 | vostigution, at my | opinori, death occi | uned at the time | o, uoto ai | io piace, air | 0 000 10 | the cease(s) |
| | Tot moo | Σ | 29b. Signature and title of certifler | 7, 00 | 11 | _) | | ise number | | | ate signed (| | |
| ١ | 6 | | I sery lande | macis, | Labor | | D4 | 1402 | 5 | au | quest | 25 | 1997 |
| _ | W | | 30. Neme and eddress of person who | completed cause of | if deeth (Item 23e) | (Type, | Print) | | | 0 | 7 | | 1997 |
| | | | M.L.M. THOMPS: | 1 | 1112 | 5 K | ROCKVILL | e Pike | Suite 10 | 3 | ROCK | ille | MD 20856 |
| | Sta | ate | 31. Date filed (Month, Day, Year) AUG 2 6 | 32. Regi | spare Signature | 7 | Danie 00 | | | - | | | |
| | Regist | | AUG 2 6 | 1991. | puna vanda | Cha-N | and the same | | | | | | |



State of Maryland / Department of Health and Mental Hygiene

27203

| | | | | | | Certi | ficate of | Death | | Reg. No. | | 41400 |
|------------------------------------|---|----------------|--|---|-------------------------------|----------------------------|---------------------------------------|-------------------------------------|---|--------------------------------|---------------------------|--|
| | Direct : | | 1. Decedent's Name (First, Middle, L | est) | | | | | 2. Date of D | eath | Visio | 3. Time of Death |
| | Physic /Medi | | La | wrence | | Mor | ganroth | า | August | 26, 199 | Year 7 | 11:07 AM |
| | Exami | | 4a. Facility Name (If not institution, ga | ve street and number) | | | | 4b. City, Town, | or Location of Deal | th 4c. Count | of Death | |
| | | | Mariner Health | | Spring | | | Silver : | | | tgome | ry |
| ò | Funerai Director | | 5. Social Security Number 6. 067-12-6652 Usual Residence of Decedent | Sex 7. Age | (In yrs. last bir 89 | | f Under 1 Year fonths Days | | Hrs. B. Date of Bi (Month, D March 1 | oy, Year) | 9. Birthi Cou Penns | place (State or Foreign ntry) Sylvania |
| | death with the Maryland ms 23s or 28s-f show Linust be notified at | | 10e. State 10b. County | | 10c. City, Tow | n or Locat | ion | | | | | 10d. Inside City Limits |
| | a Ma | ctor | Maryland Montgon | ery | Rockv | ille | | | | | | 1 ☐XYes 2 ☐ No |
| | 世 55 元 | Director | 10e. Street and Number | | | | 10f. Zip Code | | | 10g. Citizen of | What Cou | ntry? |
| | 23a | G | 261 Congressiona | 1 Lane, #7 | 11 | | 20852 | | | Unite | d Sta | tes |
| 0 | d within 72 hours after death with the Marylar plane. • than "natural", or items 23s or 22s-f show the Medical Examiner must be notified at | / Funerai | 11. Marital Stetus 1 □ Never Married 2 □ Married | 12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give | | if Y | s Decedent of Hes, specify Cub | en, Mexican, Po | (Specify Yes or No uerto Rican, etc.) | Bla | ck, White, | |
| 90 | aral, | d by | 3 Widowed 4 Divorced | Year or Detes: | | | 745 | Specify. | | Specif | Wh | ite |
| 21215-0020 | 72 ratu | Completed | 15. Decedent's E (Specify only highest g | ducation ade completed) | 16a. | (Give kin | t's Usual Occup d of work done | during most of | working | 16b. Kind of B | | |
| 12 | Part Part Part Part Part Part Part Part | d E | Elementary/Secondary (0-12) | College (1-4or 5- | | | NOT use retire | d) | | Real E | | |
| d 2 | tal Hygie d other event, th | | 17. Father's Name (First, Middle, Las | 5 | A | ttorr | ney | 18 Mother's | Name (First, Middle | Develo | | |
| Maryland | 2392 | To Be | Louis Morganrot | | | | | Rose | | | 10) | |
| ary | d 2 should be and Menta 7 is marked traumatic e | F | 19a. Informant's Name/Relationship | | 19b | . Mailing A | Address (Street | | Rural Route Numb | | State Zir | Codel |
| | and 2 polity a n 27 is er frau | | Olga Morganroth | | | | as 10 | | | | | |
| re, | the state | | 20a. Method of Disposition | | 20b. Place of | f Dispositi | | ce) | Date | 20c. Location | City or To | own, State |
| Ĕ | Pages hant of mt: If its iry or o | | 1 X Buriai 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Spec | | | * | emorial | , | 8-28-97 | Columbi | a. Ma | rvland |
| Baltimore, | permit. Pages 1 and 2 Department of Health Important: If Item 27 is any Injury or other tra snos. | | 21. Signeture of Funeral Service Lice | nstee Re | | Rap Rap | ame and Addre | ess of Fecility Call Serv | vices, P. | Α. | | |
| | | | 23e. Pert1. Enter the disease, or con | nplications that caused | the death. Do r | | | | Silver S | | של או | 0910 Approximate Interval Between |
| | Physician | | shock, or heart failure. List only | one cause on each line | 9. | | | | | | i | Onset and Death |
| l- | /Medical | | Immediate Cause (Final disease or condition | Pneumor | nia | | | | | | | 2 weeks |
| | Examiner | | resulting in death) | | Due to (or as a | conseque | nce of): | | | | | z weeks |
| | po ti | lue | | b | | | | | | | | |
| _6 | axecute | Examiner | Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying | 0. | Due to (or as a | conseque | nce of): | | | | | |
| 68760, | siciar b buri | edical | Cause (Disease or Injury that initiated events | с | | | 0 | | | | | |
| × | n certificate be executed anding physician and use as the burial-transit | 2 | resulting in death) Last | d | oue to (or as a c | consequer | ice or): | | | | 1 | |
| ă | attendi | by Physician/ | Don't Other to Many and | | | | | | 1 | | 1 | |
| o | that the death ed by the atter detached for u | hysi | Part II. Other significant conditions | contributing to death but | t not resulting in | n the unde | rtying ceuse giv | ven in Part I. | | | | the cause of death? |
| T | that ned b | y P | Severe Dementia | | | | | | _ 1 | Yes 2 A No | 3 □ Pro | babiy 4 ☐ Unknown |
| cords | The law requires that the death certificata be executed tie has been signed by the attending physician and page 2 should be detached for use as the bunal-transit | Completed b | | | | | | | 24a. Wes | s an autopsy ormed? | av | ere autopsy findings eilable prior to impletion of cause death? |
| Re | The lav | E C | | | | | | | 40 | Yes 2 No | | |
| ā | | Be C | 25. Was cese referred to medicel | | | | | 26 Piece of I | Death (Check only | | 11. | ☐ Yes 20 No |
| <u> </u> | ysician: is cartific director, | To B | examiner? 1 ☐ Yes 2 ☐ XNo | Hospital: | t 2□ER/Ou | Itpatient | 3□ DOA Oth | | g Home 5 ☐ Resi | | er (Snecit | (v) |
| Division of Vital Records, P.O. Bo | 는 는 등 | | 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation | 28a. Date of injury (Month, Day | /. 28b. T | Time of njury | 28c. Injur Wor | | | how injury occur | | ,, |
| Divis | or Attending later death. Director: Aftar in by the funer | Certification: | 3 ☐ Sulcide 6 ☐ Could not to determined | | ry - At home, fa (Specify) | rm, street | factory, office | | 28f. Location (City or To | | per or Rura | al Route Number, |
| | To the Hospital or Att within 24 hours after of To the Funeral Direct completaly filled in by | edicai | 29a. Certifler (Check only one) 11X Cartifying Plants one) 1 Medical Example 1 | nyalcian: To the best of miner: On the basis of e and magner stat | examination and | o, death oc d/or invest | curred at the tir igation, In my o | me, date and plo plnion, death o | ace, and due to the ccurred at the time, | cause(s) and madate and place, | anner as s and due to | tated. the ceuse(s) |
| | To the composition | Σ | 29b. Signature end title of comm | // | | | 29c. Licens | se number | | 29d. Dete signe | d (Month, | Day, Year) |
| | 8 | | Vill Kox | expen | | | D098 | 334 | | August | 27. | 1997 |
| | - | | 30. Name and address of person who | | ath (Item 23a) (| (Type, Prir | nt) 372 | 20 Farra | gut Aven | ue | , | |
| | | | Barry N. Rosenba | um, M.D. | | | | singtor | | 895 | | |
| | Sta Registr | te | 31. Date tiled (Month, AUG 2 7 | 1997 32. Registra | 's Signature | מל | | | | | | |
| | Hegisti | ui i | | 0 | mantage | Mr-Not | PARL | | | | | |



State of Maryland / Department of Health and Mental Hygiene 97 27201.

| | 553 | | | · | C | Certifica | te of | Death | | Reg. No. | 1 | - 1204 |
|------------|---|------------------|---|---|-----------------------------|----------------------------------|-------------------|---|-------------------------------------|-------------------------|----------------------------|--|
| П | Physici | ion | 1. Decadant's Nama (First, Middla, Last) |) | | | | | 2. Data of Dec | ath Day | Yaer | 3. Tima of Death |
| | /Medi | | RAYMOND TH | HORN MO | DRE | | | | AUGUST | 21, 199 | | 11:36 A |
| | Examir | | 4a. Facility Nama (If not institution, giva | | | | | 4b. City, Town, or I | ocation of Death | 4c. County | of Death | |
| | | | THE JOHNS HOPKINS | | | | | BALTIMOR | | | none | |
| ē | Funeral Director | | 229-05-0755 | 7. Aga (In yi | | Months | Days | If Undar 24 Hrs. Hours Min. | (Month, Da | $r^{h}_{2, Yaer)}$ 1921 | 9. Birthple Count e | aca (Stata or Foraign Iny) Xas |
| | yland m | | Usual Rasidance of Decedant 10a. Stata 10b. County | 10c. | City, Town o | r Location | | | | | 10 | Od. Insida City Limits |
| | Marylan f show | jo | Maryland Montgome | erv D | erwood | 4 | | | | | | 1 ☐ Yas 2 No |
| | r 28a | rec | 10e. Street and Numbar | | CI WOO | | o Coda | | | 10g. Citizen of V | What Count | iry? |
| | 38 0 | DE | 7121 Panorama Driv | е | | 20 | 855- | 1938 | | U.S.A | | • |
| | deati | Funeral Director | 11. Marital Status | 12. Was Dacedant Evar in | U,S. | 13. Was Dace | dant of H | lispanic Origin? (S an, Maxican, Puart | pecify Yas or No- | 14. Rac | a - Amarica | |
| 21213-0020 | 72 hours after death with the Maryland naturel; or frems 23s or 28s-f show bital Example munt be notified a | by | 1 ☐ Navar Marriad 2 🛣 Married 3 ☐ Widowad 4 ☐ Divorcad | Armed Forces? 1 ☐ Yas 2 X No If Yas, Giva Yaar or Datas: | | | | Specify: | o Ricen, atc.) | Specify | ok, Whita, a | |
| 2-0 | n 72 hours "naturel", epical Eu | Be Completed | 15. Decedent's Educ (Specify only highast grade | cation | 16a. De | ecedant's Usu | al Occup | eation during most of world) | kina | 16b. Kind of B | usinass/Indi | ustry |
| 7 | within ane. | du | Elementary/Secondary (0-12) | Collaga (1-4or 5+) | - 'iii | | | d) | All 19 | | | |
| - | Hygiar ther tr | S | 17. Fathar's Nama (First, Middla, Last) | 1 | | Engin | eer | | 450 | | .S.T. | |
| | d la b | Be | James Bernard Mo | 0.00 | | | | 18. Mothar's Nan | th Thorn | Maidan Suman | ia) | |
| 5 | should by the Menta marked amatic evaluations. | To | 19a. Informant's Name/Ralationship (Ty) | | 105 1 | Anilina Addana | - /011 | end Number or Ru | | - C'A T- | 0.4. 7 | 0-41 |
| 2 | d Z S | | Adeline S. Moore | Wife | | _ | | Drive, [| | | | 0855 |
| ນ໌ . | ges I and tof Heal | | 20a. Mathod of Disposition | 20b | Place of D | isposition (Ne | ma of | | Data | 20c. Location - | | |
| 0 | rages sent of nt: If Its iry or o | | 1 ☐ Burlal 2 🛣 Cramation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) | amoval from Stata | | cramatory or | , | | 3-22-97 | | | Maryland |
| Daltimor | - 투혈증 | | 21. Signature of Fineral Septce License | 1/11 | chesa | peake 22. Nama ai | nd Addra | ss of Facility | | | ne, | Maryland |
| ŏ | Depa Impo any Ir | | VIII. 6.1 | 1-11/201. | | Rapp | Fune | ral Serv | | | | |
| | | | 23a - art1 Enter the disease, or complished, or heart feilure. List only on | cations that caused the cla | ath. Do not | 933 G | 1St | Avenue, S | or raspiratory ar | pring, | Maryl | and 2091 (|
| P | hysician | | shoot, or heart feilura. List only on | e ceuse on aach lina. | | | , | | | | 1 | Approximata Intervet Between Onsat and Death |
| | /Medical | | Immediate Causa (Finat disaasa or condition | HYPOXEM | | | | | | | | .c 4. 0 |
| E | Examiner | | rasulting in death) | | | nsequance of) | | | | | | HE HOUR |
| | | iner | . . | CEREBRAL | | | | ACCINEN | 1 | | | Hours |
| | cernicate be executed ding physician and ise as the burial-transit | Examiner | Sequentially list conditions, | | | sequence of) | | · · · · · · · · · · · · · · · · · · · | • | | | |
| Š, | ya exe | | Sequentially list conditions, if any, leading to immediate causa. Entar Undarlying Causa (Disaasa or Injury | ATHEROS | EROT | ric t | 1.56 | ACE | | | TO | EN YEARS |
| 00/00 | ohysic the t | edicai | thet Initiated avants rasulting In daath) Last | | | sequance of): | | | | | | |
| מאס | D a | Σ. | d | I | | | | | | | | |
| 9 | Death ce | cian | | | | | | | | | | |
| 5 | 0 0 | Physician/ | Pert II. Other algnificant conditions con | tributing to death but not re | asulting in th | a underlying | cause giv | an in Part f. | | | | the cause of death? |
| L 1 | ned b | | | | | | | | 101 | res 2□ No | 3 Prob | ably 4 ☐ Unknowr |
| 5 | ine law requires that that also been signed by the page 2 should be detached. | d by | | | | | | | 24a. Was | an autopsy | | re autopsy findings |
| 3 | should | Completed | | | | | | | perfo | rmad? | com | ilabla prior to applation of ceusa leeth? |
| | e has | Ë | | | | | | | 101 | as 2000 | | |
| | iffication, pu | 80 | 25. Was casa rafarred to medical | | | | | 26 Place of Dee | th (Check only o | , | - '- | Yes 2 No |
| | r this certific | To B | axaminar? | lospital: | ☐ ER/Outpa | atlent 3 De | Oth Oth | or. | oma 5□ Rasio | | ar (Snacify |) |
| 5 8 | er thi | | 27. Mannar of Deeth | 28a. Dete of Injury (Month, Day Year) | 28b. Tim | a of | 28c. Injur Wor | | 28d. Dascribe h | | | |
| 5 | ar death. ector: After by the fune | atio | 1 Netural 5 ☐ Panding 2 ☐ Accidant invastigation | (Workit, Day Teat) | fnju | M | | Yas 2□No | | | | |
| 5 3 | aftar de Directo d in by th | Certification: | 3 Suicida 6 Could not be datamined | 28a. Place of Injury - At building, atc. (Space | | , straat, factor | y, office | | 28f. Location (S City or Tox | | oer or Rural | Routa Number, |
| Locale | To use mospinal of American propertient, the law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | edicai C | 29a. Cartifiar (Check only one) 1 Certifying Phya 2 Medicai Examin | Iclen: To the best of my killer: On the basts of axeminand menner stated. | nowladga, d nation end/o | aath occurred r invastigetion | at the tin | ne, dete and piece pinlon, daath occu | , end due to the orred at tha tima, | cause(s) end mi | anner as sta and dua to | ited. tha causa(s) |
| 40 04 | withir To th | Me | 29b. Signatura and title of cartifiar | | | 29 | c. Licans | a number | | 29d. Data signe | d (Month, D | Day, Year) |
| | 50 | | FALLE | 5 M. N | . PL.] | | RES | -000 | | AUGUST | 2.1 | 1997 |
| | _ | | 30. Name and eddrass of person who co | | | - | , , _ , | | | , 1 | | |

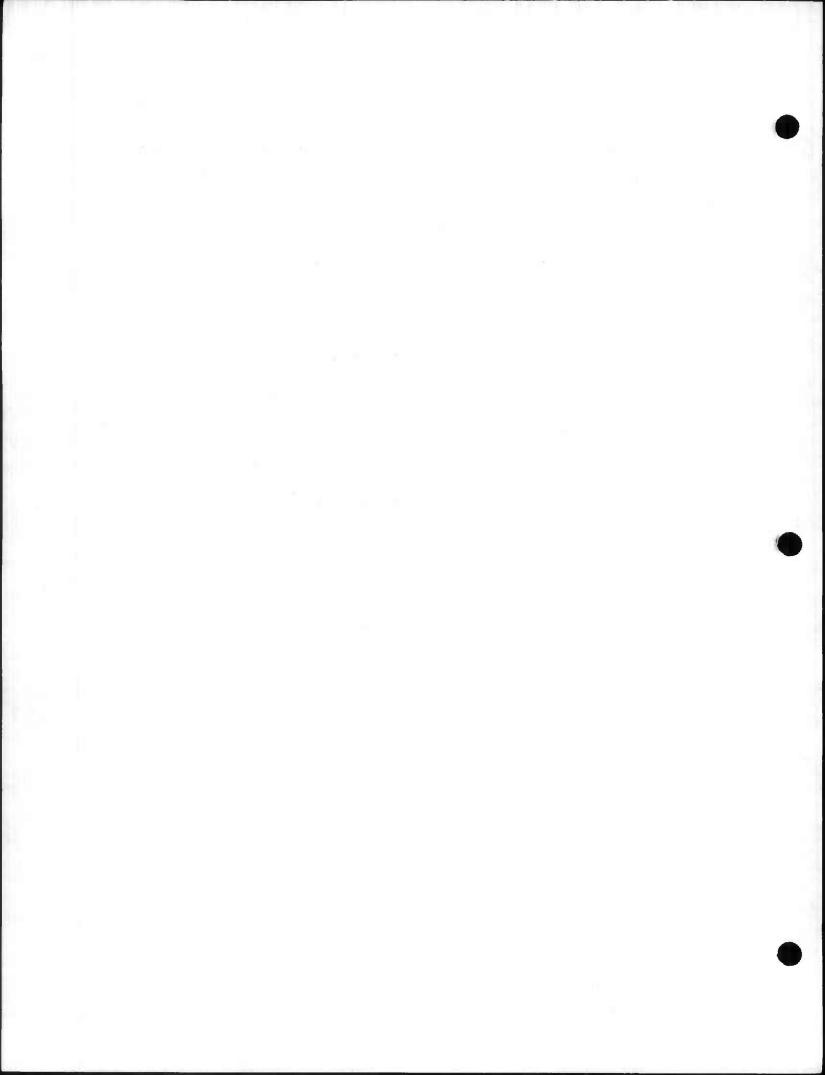
JOHNS HOPKINS HOSPITAL

State Registrar

DANIEL RUFUS BROWN, M. D. Ph.D.

HE HE HELDE! AND THE STATE OF T

| _ | | | | | | | Cei | rtificate | e of | Death | | Reg. No. | | |
|---------------------|---|------------------|--|---------------------------------------|---|---|------------------------|-----------------|-----------|--|------------------------|--------------------|---------------------------|--|
| п | Physic | ian | Decedent's Name | | , | | | | | | 2. Date of De Month | Dey | Year | 3. Time of Death |
| Л | /Medi | cal | | O. Mis | | | | | | | August | | | 3:24 AM |
| а | Exami | ner | 4a. Facility Name (If | | | | | | | 4b. City, Town, or Lo | | 4c. Count | y of Death | |
| H | | - | Washington 5. Social Security Nu | | | pital . Age (In yrs. | lant hirthday | If Under | | Takoma Pat | rk 8. Dete of Bir | | tgome | |
| | Funerai Director | | 577-56-48 Usuel Residence of I | 337 | 1□ M 21 F | 83 | Yrs. | Months | Days | Hours Min. | Feb. 3 | y, Year) | 9. Binnp Court Mary | |
| | land w | | | 10b. County | | 10c. Cit | y, Town or Lo | cation | | | | | 1 | Od. Inside City Limits |
| | Mary Frsh | to | N/A | N/A | | Was | hingto | n D | C | | | | | t Yes 2□ No |
| | r 28e | Funeral Director | 10e. Street and Num | | | Was | ningto | 101. Zip | | | | 10g. Citizen of | Whet Cour | ntry? |
| | th wit | a D | 1615 Tucl | kerman S | treet. N | . W . | | | 20 | 0011 | | U.S. | Δ. | |
| | eme - L | iner | 11. Marital Status | | 12. Was Deced | ent Ever in U. | S. 13. | Vas Deced | ent of h | dispanic Orlgin? (Spean, Mexican, Puerto | ecify Yes or No | - 14. Re | ce - Americ | |
| Maryland 21215-0020 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinet must be notified a sonce. | by | 1 ☐ Never Marrie 3 ☑ Widowed 4 | | 1 Tes 2 If Yes, Give Year or Date | . IXNo | | | | Specify: | , many etc., | Specif | fy: | ite |
| 5-0 | 72 ho | eted | (Specif | 15. Decedent's E y only highest gr | ducation | | 16a. Deced | lent's Usua | l Occup | petion | ina | 16b. Kind of B | | |
| 2 | lan " | Completed | Elementery/Secon | | College (1-4 | lor 5+) | life. | OO NOT us | e retire | during most of work d) | n ng | | | |
| 2 | hygier ther th | S | 12 | | | | Accou | nting | Te | chnician | | | | ernment |
| and | d off | Be | 17. Father's Neme (F | | • | | | | | 18. Mother's Name | | | ne) | |
| 2 | d Mark | 2 | William I | | | | 405 14-10- | - Adde- | /04 | | E. Dem | | O | |
| Z S | nd 2 should be the and Mante 27 is marked traumatic er | | | | | | | | | and Number or Run | | | | |
| re, | Hear Hear other | | Michael A. 20a. Method of Dispo | | er | 20b. P | lace of Dispo | sition (Nam | e of | n Street, | N.W. W. | 20c. Location | on, D. - City or To | C . 20011 |
| Baltimore, | Pages nent of I ant: If ite ury or of | | 1 ☐ Burial 2 ☐ 4 ☐ Donation 5 | | Removal from St | ate | emetery, cren | - | | , | 107/07 | | 1 | |
| | artmoorten | | 21. Signature of Fun | | | For | | | | tery 8, | 121/91 | Brentwo | od, Ma | ryland |
| Ö | Depa Impo any ir | | Da1. | 11. | I B | | | | | Collins I | | | | |
| | | | 23a. Part1. Enter the shock, or heart | disease, or con | nplications that fau | used the deelf | 50 n. Do not ent | Uniter the mode | vers | sity Blvd. | or respiratory e | lver Sp: | ring, | Approximete |
| | Physician | | shock, or heart | failure. List only | one ceuse offeat | ch line. | | | | | | | | Intervel Between Onsel and Death |
| | /Medicai | | Immediate Cause (F | inel | e Pneumo | nia | | | | | | | | Days |
| | Examiner | | resulting in death) | | e. The unio | | r es a conseq | uence of): | | | | | | Days |
| | sit ad | lue | | | Renal | Failur | e | | | | | | i | Months |
| | icata be axecuted physician and s the burial-transit | Examiner | Sequentially list conditions if any, leading to Immoeuse. Enter Underl | ditions, | 0. | Due to (o | r as a conseq | uence of): | | | | | | |
| 60, | be ay ician burla | al E | ceuse. Enter Underl Cause (Disease or In that Initiated events | ying njury | c. Conges | tive H | eart F | ailur | e | | | | | Months |
| 68760, | tificata be axecuted g physician and as the burial-transit | edical | resulting in death) La | ast | | Due to (or | es e conseq | uence of): | | | | | | |
| _ | | | | | d | | | | | | | | | |
| Box | that the death cer ed by the attendin detached for usa | Physician/ | Part II Other algorithm | and acoditions | | h hut ant ann | diam'r the state of | de de de de m | | on to Book t | Ook Plat | 1.h | | 45 |
| 0 | the cy the | hys | Part II. Other algnific | | | | uiting in the ui | nderlying ce | euse gr | en in Per I. | | Yas 2⊠ No | | the cause of death? |
| S, | | by P | Arteriosc | lerotic | Heart Di | sease | | | | | | 148 2kg 140 | 3 110 | ALDRY 4 OHKHOW |
| ğ | law requires as been sign 2 should be | | D1-1-6 3 | d-1124 | | | | | | | 24a. Was | an autopsy med? | 24b. We | ere autopsy findings aileble prior to |
| Record | e law re has bev ga 2 sho | Completed | Diabetes 1 | Mellitus | | | | | | | perio | illed i | CO | mpletion of ceuse death? |
| | 0 - 0 | E O | | | | | | | | | 10 | res 2 No | 10 | Yes 2 No |
| Ita | ysician: The s certificate director, pag | Be (| 25. Was case referre | d to medicel | | | | | | 26. Plece of Death | h (Check only o | ne) | | |
| 2 | C 00 D | 2 | 1 ☐ Yes 2 ☒ N | lo | Hospital: 1X Inp | | ER/Outpetien | | | 4 LI Nursing Ho | me 5 🗆 Resid | dence 6 Oth | ner (Specif) | v) |
| Division of Vital | eth. | Certification: | 27. Manner of Deeth 1 ☑ Natural | 5 Pending | | Injury Day Year) | 28b. Time of Injury | | Bc. Injur | | 28d. Describe I | now injury occur | rred | |
| Sic | Attending I at death. ector: After by the fune | cat | 2 ☐ Accident 3 ☐ Sulcide | investigation | 10 | 41.1 | | M | | Yes 2 No | 204 1 | Disease and Missel | | J. Day to March 1 |
| | or Att | art. | 4 ☐ Homlcide | determined | 286. Place of | f Injury - At ho , etc. <i>(Specif</i>) | | et, factory, | Office | | City or Tov | vn, State) | oer or mura | Il Route Number, |
| | ours ours eral | | 29a. Certifier | 177 Cartifulna Pl | nuelclen: To the he | net of my know | uladaa daath | occurred a | t the tir | me, date and place, | and due to the | nauco(s) and m | 20001 20 0 | lated |
| | 24 h 24 h Fun ately | edical | | Madical Exa | miner: On the basi | is of examinat | ion and/or inv | estigation, | In my o | ppinion, death occurr | ed at the time, | date and place, | and due to | the ceuse(s) |
| | To the Hospital or Attendi within 24 hours aftar death To the Funeral Director: A compiately filled in by the f | Me | 29b. Signeture end ti | tle of ertifier | | 147 | | 29c. | Licens | se number | | 29d. Dete signe | ed (Month, | Dey, Yeer) |
| | 0 | | 1 | 1 | MI | 7 | | D | 080 | 080 | | 27K | 2561 | 2 |
| | 1- | | 30. Neme end address | s of person who | completed cause | of deeth (Item | 23e) (Type, | | UOL | 007 | | V | / | / |
| | | | Michael 1 | Leibowit | z. M.D. | , | | , | ire | Avenue S | Silver | Spring. | MD 2 | 0904 |
| | Sta | ate | 31. Date filed (Month | ATIGO O | 1007 32. Reg | intrar's Signal | ture 10 | -1.00 | | | | | | |
| | Registr | rar | | 1990 | 1001 | | I HOUSE-NO | - Indian | | | | | | |



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 27206

| -11- | | | | | | Ce | rtificate o | f Death | | | Reg. No. | | |
|-------------------|--|----------------|--|--|---|------------------------------|--|-------------------|---------------------------|------------------------------|---------------------|--------------|--|
| | | | Decedent's Neme (First, Middle | , Last) | | | | | | 2. Dete of De Month | | Vaca | 3. Time of Deeth |
| | Physic /Medi | | Violet Louise | Mille | r | | | | 4 | | 24, 199 | Yeer 7 | 12:38 PM |
| N. | Exami | | 4e. Fecility Neme (If not institution, | give street and n | umber) | | | 4b. City, To | wn, or Loc | cation of Deeth | 4c. Count | of Deeth | |
| 7 | | | Shady Grove Adv | entist H | ospital | | | Rockv | ille | | Montg | omery | 7 |
| т | Funeral | | | 6. Sex | | . last birthday) | If Under 1 Yes | | 24 Hrs. | 8. Dete of Bir (Month, Da | | | niece (State or Foreign |
| | Director | | 312-20-1812 | 1□M 2対F | 73 | Yrs. | Months Day | s Hours | Min. | Reb. 18 | y, Year) | Indi | ana |
| | ס | | Usuel Residence of Decedent | | | | | | | | , | | |
| | ylan how | | 10e. Stete 10b. County | | 10c. C | ity, Town or Lo | cation | | | | | 1 | 0d. Inside City Limits |
| | Ma | to | Maryland Montg | omery | R | ockvill | .e | | | | | | 1 ☑ Yes 2 ☐ No |
| | r 28 | Director | 10e. Street end Numbar | | | | 10f. Zlp Code |) | | | 10g. Citizen of | What Coun | itry? |
| | h wit | = | 618 Nelson Stree | et | | | 208 | 50 | | | United | Stat | es |
| | deat | Funeral | 11. Maritel Stetus | 12. Wes De | cedent Ever in l | J,S. 13. | Was Decedent of f Yes, specify Cu | f Hispenic Orig | gln? (Spec | city Yes or No | | e - Americ | an Indien, |
| 0 | after vr its | 3 | 1 ☐ Never Merried 2 ☑ Mamle | | 2 No | | | | i, Puerio F | tican, etc.) | | ck, White, | etc. |
| 02 | urs . | b | 3 Widowad 4 Divorced | If Yes, G Year or | ive Detas: | | 1□Yes 2⊠N | o Specify: | | | Specia | Whi | te |
| 21215-0020 | 72 hours after death with the Maryland natural', or items 23e or 28e-1 show dicel Examiner must be notitled at | Completed | 15. Decedant | s Education | 13 | 16a. Dece | lant's Usuel Occ | upetion | 4 - 6 - 6 1 1 | | 16b. Kind of B | usiness/inc | dustry |
| 21 | hin 7 | pe | (Specify only highas) Elamantary/Secondary (0-12) | Ť | (1-4or 5+) | lifa. | kind of work don DO NOT usa rati | ired) | t of workin |)g | | | |
| 2 | filed within Hygiena. Ither than | E O | 12 | - | (1 401 01) | H | lomemake | r | | | Own | Home | |
| P | othe othe | Be | 17. Fether's Neme (First, Middle, L | ast) | | | | 18. Mothe | r's Name | (First, Middle, | Maidan Sumai | na) | |
| a | lid be fental ked o | ToE | Emery Allen | | | | | May | vis | Henle | У | | |
| Maryland | 2 should be end Mental s marked o | | 19a. Informant's Name/Reletionsh | lp (Type, Print) | | 19b. Mailir | ng Address (Stre | et and Numbe | er or Rural | Route Numbe | er, City or Town | , State, Zip | Code) |
| | PELD | | Charles Aldin M | iller- Hi | ichand | 618 N | lelson S | troot | Pool | willo | Marrila | nd 20 | 1950 |
| ā, | tem othe | | 20e. Method of Disposition | LIICI III | | Piece of Dispo | sition (Name of | (and | LOCK | Date | 20c. Location | - City or To | wn, State |
| 5 | Pages nent of I nt: If its iry or o | | 1 ☑ Burial 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (Sp | | State | cemetery, crei | sition (Name of matory or other p ek Cemet | August | 30, | 1997 | Wallace | Tn | diana |
| Baltimore, | | | 21. Signature of Fuperal Service L | | WO | | | | | | | | eral Home/ |
| Ba | Departi Departi importa eny infe | | \ \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\ | 77/ | | Ro | ckville | , Inc. | 300 | West | Montgom | ery A | venue, |
| _ | | | My My | with | M0068 | | ockvill | e, Mary | yland | 20850 | -2805 | | |
| | | | 23e. Part I Enter the desese, or o | complications that nly one cause on | caused the dee each line. | th. Do not ent | er the mode of d | ying, such es | cardiec or | r respiretory e | rrest, | | Approximete Intervel Between |
| | Physician | | 400 | | | | | | | | | 1 | Onset end Death |
| | /Medicai Examiner | | fmmedie Ceuse (Finel disease or condition resulting in daath) | . Ce | rebrova | scular | Accider | nt | | | | | Immediate |
| | | L | resuming in deatin) | | Due to (| or es e consac | uence of): | | | | | i | |
| | D ii | in e | | b | | | | | | | | | 3 years |
| | end -tran | Examiner | Sequentially list conditions, | | Dua to (| or as a consec | uence of): | | | | | 1 | |
| 90, | oe ax | | Sequentially list conditions, if eny, leeding to immadiete cause. Enter Underlying Ceuse (Disaese or Injury | C | | | | | | | | i i | |
| 68760, | certificate be axecuted iding physician end ise as the buriel-transit | //Medical | thet Initiated avents resulting In death) Lest | 0 | Due to (| or es e consaq | uence of): | | | | | | |
| | E 0 d | Me | | ٠, | | | | | | | | | |
| Box | | an | · | G | | | | - | | | | | |
| | dea he et he et | Physiciar | Pert II. Other significent condition | e contributing to | deeth but not ras | sulting In tha u | nderlying cause (| given in Pert I. | | 23b. Dld | tobacco use co | ntribute to | the cause of death? |
| P.0 | res thet the de signed by the e be detached i | 2hy | | | | | | | | 10 | Yee 25 No | 3 Prot | pably 4 Unknown |
| | an de de | by | | | | | | | | | | | |
| rd | law requires thet the death as been signed by the etta s 2 should be detached for | | | | | | | | | | en eutopsy rmed? | 24b. We | ere eutopsy findings eilebie prior to |
| 00 | aw re | olet | | | | | | | | peno | initiou! | co | mpletion of cause daath? |
| Re | 0 - 5 | Completed | | | | | | | | 10 | Yes 2⊠No | | Yes 21 No |
| of Vital Records, | i cian : The certificeta rector, pag | | 25. Was case referred to medical | | | | | 00 51 | - (D 1) | | 7/ | 1 | THES ZEEINO |
| 5 | | o Be | axaminer? 1 ☐ Yes 2 ☑ No | Hospital: | |] = D/O + - # - | | Whor | | (Check only o | | | |
| | | To | 27. Manner of Deeth | 28e. Dete | | ER/Outpetier 28b. Time of | | | | | dance 6 Ot | | γ) |
| on | ding F h. After funer | tion | 1 ⊠Naturat 5 ☐ Panding | (Moi | nth, Day Year) | Injury | W | /ork? □Yes 2□! | | | ,, | | |
| Division | il or Attanding safter death. Director: After d in by tha fune | Certification: | 3 Suicide 6 Could no | ot be | e of Injury - At h | ome farm str | eet, factory, offic | | | 8f. Location / | Straet and Num | ber or Rura | l Routa Number, |
| <u>≥</u> | 7 2 2 2 | T. | 4 Homicide determin | | ling, etc. (Speci | | bot, factory, offic | | | City or To | vn, State) | 0. 0. 110.0 | . Trodia Traingor, |
| | To the Hospital or within 24 hours afte To the Funeral Dir completely filled in | | 29a. Certifier 1⊠ CertifyIng | Dhualalan, T. Al- | - h 1 | | | Alman daka an | d | and alone has the a | | | |
| | Hos 24 ho Fun tely | edicai | | Physician: To the k xaminar: On the t | pasis of examine | etion end/or In | estigation, In my | opinion, daat | a piece, et th occurre | d et tha time, | data end place, | and dua to | the causa(s) |
| | the mple | Mec | 122 22 November 122 | ena mei | nner steted. | | 20c Lice | nse number | | | 29d Data signs | d (Month | Oay Voorl |
| | | | 29b. Signature and title of certifier | / | ٨ | | -2.7. | | | | 29d. Dete signe | | |
| | 10 | | 15/2 | ou | TIM | > | D50: | 213 | | | Augus | t 27, | 1997 |
| | , | | 30. Neme end eddrass of person w | | | | | | | | | | |
| _ | | | Eric C. Greenbe | erg, M.D. | | | 25 Rocky | ville F | Pike | #103, | Rockvil | le, M | D 20852 |
| | Sta | _ | 31. Dete filed (Month, Danie) | 9 199732. | Registrar's Sign | ature 9 | 2 | | | | | | |
| | Registi | ar | | - 1001 | 0 | -w/1001/v-/ | more | | | | | | |

State of Maryland / Department of Health and Mental Hygiene

27207 Certificate of Death

| | | | | | | 00 | imoute | 01 | Doam | | Reg. No. | | | |
|------------|---|----------------|--|--|--------------------------------|-----------------------|---------------|------------------|--------------------------------------|------------------------------------|------------------------------|-------------------------------|----------------------|----------------------|
| | | | 1. Decedant's Nama (First, Middla, Li | est) | | | | | | 2. Data of D | | | 3. Ti | ma of Death |
| | Physic | | Hazel B. Mc | boo! | | | | | | Augus t | - 25 | Yaar 1 O O 7 | 10 | 30 AM |
| | /Medi | | 4a. Facility Nama (If not institution, gir | |) | | | 1 | 4b. City. Town, o | or Location of Dea | | ounty of Death | | JU AM |
| | Exami | ner | The second secon | | | | | | | | | | | |
| H | | | Aspenwood Retire 5. Social Sacurity Number 6. | | | ast birthday) | If Undar | Vaar | Silver S | pring | | ntgomen | | |
| ٠. | Funeral | н | | 1 M 2 S F | | Yrs. | | Days | | n. (Month, L | lay, Year) | | | itata or Foraig |
| | Director | | 577-58-2080 Usual Rasidance of Dacedant | | 90 | | | | | Dec. 3 | 0,1906 | Mic | higa | n |
| | and * | | 10a. State 10b. County | | 10c. City | , Town or Lo | ocation | | | | | T | 10d Insi | ida City Limits |
| | Sho | 5 | | | | | | | | | | | | Yas 210 No |
| | Ne N | 9Ct | Maryland Montgo | mery | Sil | ver S | - | | | | | | | |
| | # 8 B | Director | 10e. Street and Number | | | | 10f. Zip (| Coda | | | 10g. Citiza | n of What Co | untry? | |
| | 23a | ā | 14400 Homecrest | Road #127 | 1 | | | 09 | 0 0 | | | 5.A. | | |
| | is within 72 hours after death with the Maryland ilene. I than "natural", or flems 23a or 28a-f show the Modical Examiner must be notified at | Funerai | 11. Marital Status | 12. Was Decadant Armed Forcas | Evar in U,S | S. 13. | Wes Deceda | ent of fv Cub | Hispanic Origin? can, Maxican, Pu | (Specify Yas or Narto Rican, atc.) | lo- 14 | . Race - Amar Black, White | | an, |
| 0 | or it | | 1 ☐ Navar Marriad 2 ☐ Married | 1 ☐ Yas 2 ☐ if Yas, Giva | | | 1□ Yas 2 | | | | | pecify: | , 410. | |
| 000 | ral', | i by | 3 ⅓Widowed 4 ☐ Divorced | Yaar or Datas: | | | 140 2 | 90110 | ороону. | | 3/ | | hite | |
| 21215-0020 | 72 h natu | Completed | 15. Decedant's E (Specify only highast gr | ducation | | 16a. Dece | dant's Usual | Occu | pation duning most of и | mrkin n | 16b. Kind | of Businass/I | ndustry | |
| 21 | within ene. than " | pje | Elamantary/Secondary (0-12) | Collega (1-4or | 5+) | lifa. | DO NOT use | ratire | ed) | orning | | | | |
| 21 | giene. | No | 12 | | | Perso | nnel S | pe | cialist | | Feder | ral Gov | verni | nent |
| pL | be filed tal Hygie of other event, ti | Be | 17. Fathar's Name (First, Middla, Las | " | | | | | 18. Mothar's N | ama (First, Middi | ia, <i>Maid</i> en Su | imeme) | | |
| Maryland | should be filed and Mental Hygi marked other umatic event, I | To E | Frank Burger | | | | | | Emma | C. Bleck | | | | |
| ary | end No. | - | 19e. Informant's Name/Ralationship | (Type, Print) | | 19b. Maili | ng Address | (Stree | t end Number or | Rural Routa Num | her City or T | own, Stata, Z | ip Coda) | |
| Σ | | | Barbara Ann Bola | nd | | | | | | Silv | er "Spi | ring,Ma | ryla | and 1906 |
| e, | - 4555 | | 20a. Mathod of Disposition | II d | 20b. Pl | ace of Dispo | sition (Nam | a of | isure Wo | Data | | tion - City or | | |
| 0 | nt of | | 1 ☐ Burial 2 ☐ Cramation 3 ☐ | | | • | matory or oth | | · . | | | | | |
| Baltimore, | permit. Pages 'Department of H Important: If its any injury or of | | 4 □ Donetion 5 □ Othar (Speci | | Met | - | | | matory | 8/26/97 | Alexar | ndria, | Virg: | lnia |
| 39 | Depariment Important | | 21. Signiful of Funaral Sarvica Lica | nsaa - 1 | | | | | ass of Facility Collin | s Funera | 1 Home | Tnc. | | |
| 4 | 001 8 Q | | John L | Chiple | | | | | rsity B1 | | | | | 20901 |
| | | | 23a. Part 1 Ernar tha disaasa, or con shock, of heart feilure. List only | ptications that causa | d tha daath | . Do not an | ar tha moda | of dy | ing, such as cerd | iac or raspiratory | errest, | | Appro | ximata et Between |
| | Physician | | U son is and | 0.10 00000 01. 0001. | | | | | | | | | Onsat | and Death |
| Ш | /Medical | | Immadiata Causa (Final | | | | | | | | | | | |
| | Examiner | | disaasa or condition rasulting in daath) | a.Myocardi | | | | | | | | 1 | Imme | ediate |
| | | ē | | | Dua to (or | as a conse | quance or): | | | | | 1 | | |
| | betr | Examiner | | b | D - 1- 1- | | 1 0 | | | | | | | |
| _6 | eath certificete be asscuted attending physician end for use as the buriel-trensit | Xa | Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Ceuse (Disaasa or Injury | | Dua to (or | as a consec | quence ot): | | | | | 1 | | |
| ox 68760, | be a siclar buri | | Cause. Entar Undarrying Ceuse (Disaasa or Injury thet initieted avents | c | | | | | | | | 1 | | |
| 387 | phys the | S S | rasulting in death) Last | | Dua to (or | as a consec | juance of): | | | | | 1 | | |
| × | ding ding | an/Medical | L | d | | | | | | | | | | |
| Bo | ath c | lan | | | | | | | | | | | | |
| o | t the deal by the att | /sic | Part II. Other algnificent conditions of | contributing to death b | out not resul | Iting in tha u | ndarlying ca | usa g | ivan in Part I. | 23b. Di | d tobacco us | e contribute | to the ca | use of death |
| Φ. | ed by datac | Physici | Cerebrovascular | Inquifficia | 222 | | | | | 1 | Yes 2 🔯 | No 3□Pr | obably | 4 Unknow |
| | igner bed | þ | Cerebrovascular | Insulticle | псу | | | | | - | | | | |
| Records, | v requires that been signed b should be date | P | 61 4 7 | | | | | | | | is an autopsy formad? | 24b. V | Vera auto | opsy findings |
| 2 | > 10 | Completed | Chronic Pancreat | itis | | | | | | par | TOTTINGT | 0 | complation of deeth? | n of causa |
| R | The lav ata has paga 2 | Ē | | | | | | | | 45 | 1Vaa 0□ | No | □ Vee | 2□ No |
| Vital | | ပိ | Chronic Renal In | sufficienc | <u>y</u> | | | | | | Yas 2 🖁 | 140 | LI Tas | 2LI NO |
| ₹ | ysician: T s certifical director, p | 00 | 25. Was case rafarred to medical axaminar? | Hospital: | | | | Ot | har | eath (Check only | | | | |
| ō | Physician: this certific ral director. | 은 | 1 Tyes 2 No | 1 LI Inpatii | | ER/Outpatier | | ١, | 4 Li Nursing | Homa 5 Ra | | | cify) | |
| | | 0 | 27. Mannar of Daath 1 StNeturel 5 ☐ Panding | 28e. Deta of Inju (Month, Da | ay Yaar) | 28b. Time o Injury | | c. Inju | | 28d. Dascribe | now injury o | occurrad | | |
| Sic | Attending or death. | cat | 2 Accidant Invastigatio | | | | М | 1 [|]Yas 2□No | | | | | |
| Division | | Certification: | 3 ☐ Suicida 6 ☐ Could not be datarminad | 28a. Place of In | jury - At hor ic. (Specify) | ma, farm, sti | aat, factory, | offica | | 28f. Location City or T | (Street and I own, Stata) | Vumbar or Ru | ral Routa | Numbar, |
| 0 | rs after or all Dir | Ce | | , , , | , .,,, | | | | | | | | | |
| | bour mera ly fills | | 29e. Certifier 1 Certifying Pt | ysictan: To the best | of my know | ladga, daati | occurred a | tha t | ima, data and pla | ce, and dua to th | a causa(s) ar | nd manner as | stated. | |
| | n 24 n F. n F. | edicai | (Check only 2 ☐ Medical Examone) | niner: On the basis o end menner st | t examinati ated. | on end/or in | vestigetion, | n my | opinion, daath oc | curred at the time | e, dete and pl | eca, and dua | to tha ca | use(s) |
| | To the Hospital or within 24 hours after To the Funeral Dir completaly filled in | × | 29b. Signatura and title of cartifiar | | | | 29c. | Lican | sa number | | 29d. Data | signed (Month | , Day, Ye | ear) |
| | | | | | | | - Common | | | | | | | |

State Registrar 30. Neme and address of person who completed cause of death (Item 23e) (Type, Print)

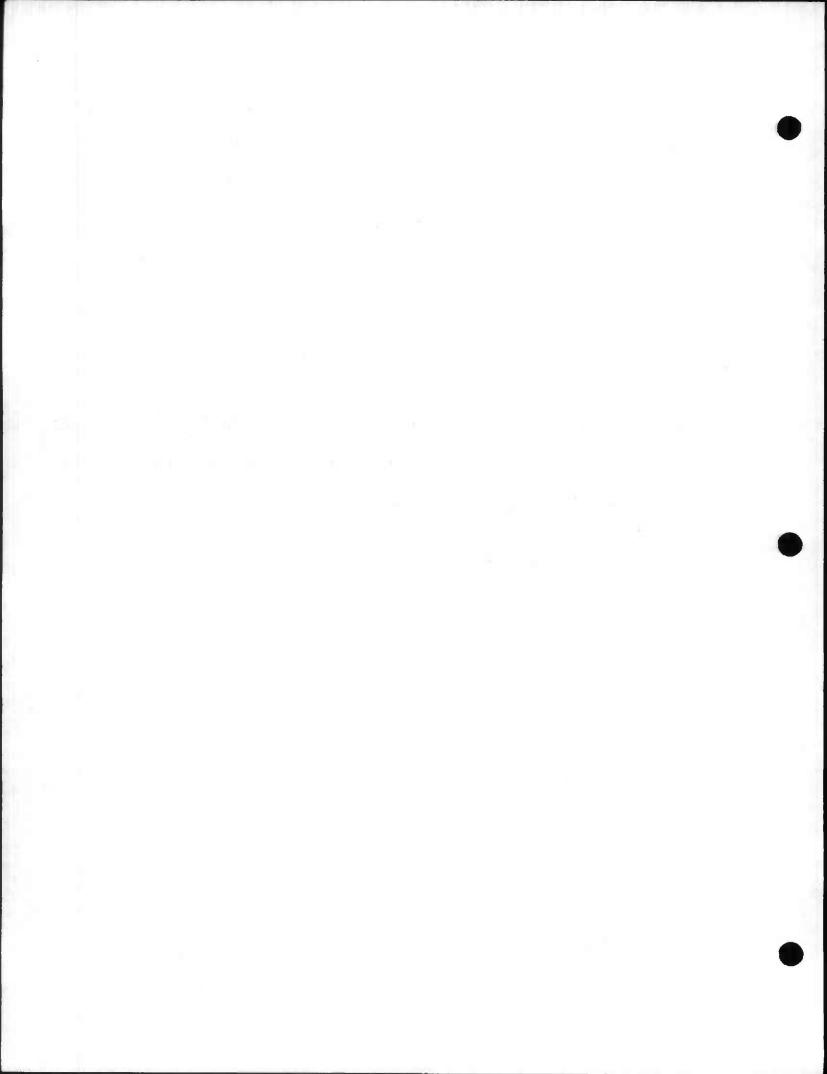
Phillip G. Henjum, M.D. 3416 Olandwood Court #200 Olney, Maryland 20832

August 26, 1997

10

Dr. John Tauber

released by



State of Maryland / Department of Health and Mental Hygiene 97

| | _ | | | | Cen | ificate of | Death | | Reg. No. | | |
|--|-----------|--|---|-----------------------|--------------------------------------|---|--------------------------------------|---|-------------------------|----------------|---|
| Physicia /Medica | | 1. Decedant's Nama (First, Middla, BREN | | B. 1 | NCC | ART | HY | 2. Data of D Month | Day 24 | Yaar 97 | 3. Tima of Death |
| Examine | | | ounty Sax 7.1 | Me ga (In yrs. las | mari | If Undar 1 Yaar Months Days | 4b. City, Town, of All | rs. 8. Data of B | M D. Count | Gar | reA |
| Director | | 579-54-7000 Usual Rasidance of Dacadant | 1XM 2□F | 52 | Yrs. | Days | TIOUIS IN | | | | chusetts |
| death with the Meryland ms 23s or 28s-f show realt be notified at | tor | 10a. Siaia 10b. County Maryland Montgo: | merv | | rown or Loca | | | | | 10 | d. Insida City Lii |
| or 284 | Director | 10e. Sireei and Numbar | | | 1111000 | 10f. Zip Code | | | 10g. Citizan of | Whai Countr | y? |
| | Funeral | 13613 Esworth 11. Marital Status 1 Navar Married 20 Married | 12. Was Decedant Armed Forcas | t Evar in U,S. | 13. W | 2087 as Dacadani of Yas, specify Cub | | (Spacify Yas or Narto Rican, aic.) | lo- 14. Ra | d Stat | n Indian, |
| ali, or | ò | 3 Widowad 4 Divorced | 1 X Yas 2 □ If Yes, Giva Yaar or Datas: | 1968- 1974 | 11 | □Yas 2【No | Specify: | | Specif | y: Wi | nite |
| n 72 hours effer *natural; or ite | Completed | 15. Decedant's (Specify only highast | rada com <i>plated)</i> | | 16a. Decede (Giva ki | nt's Usual Occu ind of work done O NOT usa ratire | pation during most of w | vorking | 16b. Kind of B | | stry |
| Hed within Hygiene. Wher than ent, the Mo | E | Elemantery/Secondary (0-12) | Collage (1-4or 4 | | | | he Board | | Real E | | |
| Mental Hyg arked other atic event, | lo Be C | 17. Fethar's Nema (First, Middla, La William J. Mc | , | | | | 18. Mothar's N | ama (First, Middle | | ma) | |
| and Men is marka aumatic | - | 19a. Informant's Name/Ralationship | | | 19b. Mailing | Addrass (Stree | | hea G. (| | , State, Zip C | Coda) |
| popular register and popular register and moortant: If tem 27 i any injury or other transcreet. | | Mary Christina N 20a. Mathod of Disposition 1 ⊠ Burial 2 □ Cramation 3 4 □ Donation 5 □ Other (Spa 21. Signature of Funeral Service Lice | □Ramovai from Siafa | 20b. Plac cem | a of Disposi atary, crams of H | tion (Nama of topy or other plane) eaven C Nama and Addrese ert A. Pu | emetery ass of Facility mphrey Fu | Darnesto Daia 30, 1997 Ineral Home Bethesda | 20c. Location Silver | Spring Chevy | m, Stata g, Maryla Chase, l |
| hysician end ding physician end was the bundal-transit and the purial-transit and the puria | хашпег | 23a, Part Enter the disease, or constitute, or heart failure. List on immediata Causa (Final disease or condition rasulting in daeth) Sequentially list conditions, if any leading to immediate | ARTER My6 | | CLEY s a conseque | 20TIC (anca of): AL I | | | | | ntarval Batweer |
| nding physicla use as the bur | Medical | Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaase or injury thai initiated avanis rasulting in daath) Last | c | Dua fo (or as | a conseque | ince of): | | | | i i | |
| ad by the etterdeched for | II yalcı | Part II. Other significant conditions | contributing to death b | out not resulting | ng in tha und | ariying ceusa gi | van In Part I. | | tobacco uss co | ontributs to t | |
| been signed should be d | 2 | | | | | | | 24a. Wa | s an autopsy formad? | avall | a autopsy findin lable prior to pletion of cause seth? |
| ate hes | 5 | | | | | | | 1 🗆 | Yas 25 No | 10 | Yas 2□ No |
| certificate rector, pag | D | 25. Was case referred to medical axaminar? | | | | | 26. Placa of D | eath (Check only | ona) | | |
| S T D | - - | 15 ∠as 2 No 27. Mannar of Death | Hospital: | | /Outpalient | 3LI DUA | | Homa 5 ☐ Ras | | | |
| or: After the fune | IIcarioli | 1 Neturei 5 Pending 2 Accidant investigati 3 Suicida 6 Could noi | ba Dines of In | y Year) | b. Tima of Injury | | ryat rk? Yas 2 □ No | | how Injury occur | | Routa Number. |
| s after d al Direct ed in by | 5 | 4 Homicida | building, at | c. (Specify) | , | ,, | | | wn, Stata) | | |
| Funer Funer tely fill | | | hysician: To the bast miner: On the basis o and mannar st | f axamination | | | | | | | |
| To the | - | 29b. Signalura and title of certifier Paul Dom | io amile | Dan & | ð. | 29c. Licans | 26/S | -4 | 29d. Data signe | d (Month, De | y, Year) |
| F | 1 | Name and eddress of person who | riller De | 20 | DEVY | AVUA | nd Hog | Lwast | 6 m | UHK 2 | 113C |
| State Registrar | | 31. Date filed (Month, AUS 29 | 1997 32. Hogist | ar's Signature | on-Pan | dell | | 0 | | | |

the same of the formula of the second of Managan and the east we will be a beginning to recent

State of Maryland / Department of Health and Mental Hygiene 97 27209

| | | | | | | Ce | rtificate of | f Death | | Reg. No. | | |
|------------|--|----------------|---|---------------------------|-------------------|---|--|---|-------------------|----------------------|---------------|-------------------------------------|
| П | | | 1. Dacedent's Neme (First, Middle | , Last) | | | | | 2. Date of De | | | 3. Time of Deeth |
| | Physic | | Cornelia Kirb | v Mateon | | | | | Month August | 24, 199 | Yaar 7 | 6:20 PM |
| я | /Medi | | 4a. Facility Nama (If not Institution | | mber) | | | 4b. City, Town, or I | | | | 0.20 111 |
| | Exami | ner | 100 miles | | ,,,,,, | | | | | | | |
| Н | | | 9503 Bruce Dri 5. Social Security Number | | 7 Ama /In com | In as to laste day. | If Undar 1 Yaa | Silver Sp ir If Undar 24 Hrs. | | | gomer | 4 |
| | Funeral | Н | | 6. Sex 1 ☐ M 2 ☑ F | 7. Aga (In yrs. | Yrs. | Months Dey | | (Month, De | ly, Year) | 9. Birthpl | lace (State or Foraign try) |
| | Director | | 577-03-9312 Usual Residence of Decedent | • | 85 | 173. | | | Sept. 25 | ,1911 | Mary | land |
| | pu * | | 10a. Stata 10b. County | | 10c. Cit | ty, Town or Lo | ncation | | | | 10 | Od. Inside City Limits |
| | anylia sho | 2 | | | 100.0 | .,, , , , , , , , , , , , , , , , , , , | odation | | | | | 1 ☐ Yas 2 ☑ No |
| | Ne M | ctc | Maryland Montg | omery | Sil | ver Sp | oring | | | | | TI TAS ZĄĘNO |
| | 72 hours efter death with the Maryland natural; or itams 23a or 28a-f show | Director | 10e. Street and Number | | | | 10f. Zip Code | | | 10g. Citizen of | What Count | ry? |
| | th w | | 9503 Bruce Driv | e | | | 209 | 901 | | U.S. | Α. | |
| | dea Final | Funerai | 11. Marital Status | | dent Ever in U | ,S. 13. | Was Decedent of | Hispanic Origin? (S ban, Mexican, Puerl | pecify Yas or No | | e - America | |
| 0 | or its | F | 1 Navar Marriad 2 Marr | ed 1 Tes | 2 No | | | | o moan, etc.) | 7.7.1.1.1 | ck, White, a | .IC. |
| 02 | urs | by | 3K Widowed 4 ☐ Divorced | If Yes, Giv Year or Da | | | 1 ☐ Yes 2 ∏ No | Specify: | | Specify | v: Whi | +0 |
| 21215-0020 | 72 hours ef "natural", or | Completed | 15. Deceden | 's Education | | 16a. Dece | dent's Usual Occi | upation | | 16b. Kind of B | | |
| 75 | C | pie | (Specify only highes | T - | 14 | (Give | kind of work don- DO NOT use retir | e during most of work ed) | king | | | |
| 7 | 3 5 5 8 | E | Elementary/Secondery (0-12) | College (1 | -40r 5+) | Н | omemaker | | | Own H | ome | |
| P | a tage | | 17. Father's Name (First, Middla, | | | 110 | Jin Cina RC I | 18. Mother's Nan | ne (First, Middle | | | 7.0 |
| an | 0 % D 9 | Be | 772 7 7 2 7 1 | 4 77 d - a l - a | | | | C1 | . Wand- | D | | |
| 2 | should be and Mental marked of umatic eve | ဥ | William Lamber 19a. intorment's Neme/Relations | | | 105 11-70 | | | ia Maude | | | |
| Maryland | | | 134. Intofficent's Neme/Helations | iip (Type, Print) | | 19b. Maiii | ing Address (Stree | et end Number or Ru | rei Houte ivumb | er, City or Town, | State, Zip | Loge) |
| | of Health of Itam 27 is | | John P. Matso | n | loot 5 | | Stephens | s Road V | | | | ia 23454 |
| 0 | of the | | 20e. Method of Disposition 1 Burial 2 Cremation | 3 DRemoval from 5 | | cemetery, cra | osition (Ñama of matory or other pi | lace) | B/28/97 | 20c. Location - | City or Tov | vn, State |
| Ē | Peges nent of ant: If Its | | 4 ☐ Donetion 5 ☐ Other (S | | | orge Wa | ashington | n Cemetery | | Adelphi | . Marv | land |
| Baltimore, | permit. Peges Depertment of Important: If it any injury or once. | | 21. Signature of Funeral Service | icensee | | 2 | 2. Name and Add | ress of Facility | | - | | |
| œ | Depermination of the second of | | 1til 011 | | | F | rancis J | . Collins | Funeral | Home, | Inc. | |
| | _ | | 23a. Part1. Enter the diseasa, or | complications that o | ounced they don't | 5(| 00 Unive | rsity Blvd | 1.,W.,Si | lver Sp | ring, | MD 20901 Approximate |
| | | | shock, or heart tailure. List | only one causa on a | ech line. | II. DO NOT BIT | ter the mode or dy | ring, such as cardiac | or respiratory a | 11631, | | Interval Between Onsat and Death |
| 1 | Physician / | | tological and the | | | | | | | | 10 | Olisat and Death |
| 1 | /Medical Examiner | | Immediata Cause (Final disease or condition | a Multi | Infaro | ct Deme | entia | | | | | |
| | Examine | | resulting in death) | | | or as a conse | | | | | | |
| | D .E | ne | | Hyper | tension | 1 | | | | | | |
| | ertificate be executed sing physicien end se es the buriel-transit | Examiner | Sequantially list conditions, | 0, 37 | | or as e conse | quence ot): | | | | | |
| ó | en e | | if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury | | | | | | | | i | |
| 68760, | ysici | /Medicai | that initiated events | C | Dua to (o | r as e consec | quence ot): | | | | | |
| 9 | lifica g ph es th | ed | resulting in death) Last | | | | ,,- | | | | 1 | |
| XO | 0 6 3 | 2 | | d | | | | | | | | |
| m | death e etter | Physician | Port II. Other elections and the | | | | | t t- B. 41 | ach Did | A.b | | Ab a save and develop |
| 0 | 5 E E | ys | Part II. Other algnificant condition | na contributing to de | ain out not res | uiting in the u | indenying ceuse g | liven in Part I. | | | | the causa of death? |
| 0 | 2 D 8 | | Cerebral Anev | rysm | | | | | 1 | Yee 20 No | 3 Prob | ably 4 Unknow |
| ds, | 8 50 | 1 by | | | | | | | 04-144 | The residence of | 24h Wo | re autopsy findings |
| Record | v requires been sign should be | Completed | | | | | | | | an autopsy ormed? | ava | illeble prior to |
| ec | S S | ğ | | | | | | - | | | ot d | leeth? |
| | 0 - 2 | 0 | | | | | | | 10 | Yes 2 No | 10 | Yes 2 No |
| Vital | lcian: The certificate rector, pag | Bec | 25. Wes case referred to medicel | | | | | 26. Place of Dea | ith (Check only i | one) | | |
| > | Physician: this certific ral director, | 0 | examiner? 1 ☐ Yes 2 ☑ No | Hospitel: | npatient 2 🗆 | ER/Outpatie | nt 3 DOA O | ther _ | | dence 6 Doth | er (Snecify | d |
| of | | Ξ. | 27. Manner of Death | 28a. Date o | of Injury | 28b. Time o | 1 | | | how Injury occur | | / |
| on | ding F After funer | tior | 1 Neturel 5 Pendin | 5 | h, Day Year) | Injury | | ork? □Yes 2□No | | | | |
| Division | or Attending efter death. Director: Afte I in by the fune | Certification: | 3 Suicide 6 Could r | ot be | ot Injuny - At he | ome tarm et | reet, factory, office | | 28f Location / | Street end Numi | her or Rura | Route Number |
| 5 | or At efter of Direct | T . | 4 Homicide determ | | ng, etc. (Specif | | reet, ractory, ornor | | City or To | wn, State) | 501 01 110.0. | riodio ridinoci, |
| J | To the Hospital or within 24 hours efter To the Funeral Director Completely filled in the Funeral C | - 1 | no. Carilla | | | 255,010,000 | | 5 | | | | |
| | Hose Tune | edicai | (Check only 2 Medicel ! | | | | | time, date and place opinion, death occu | | | | |
| | the trin 2 the f | led | one) | end mann | ner stated. | | | | | | | |
| | To To | Σ | 29b. Signature and title of certified | Marie | 20/11 | 1 | 29c. Licar | nsa number | | 29d. Data signe | d (Month, E | Jay, Yaar) |
| | 0 | | / cesset | July | YVVVI | | ם | 25344 | | August | 25.19 | 97 |
| | D | | 30. Name and address of person | vho completed cause | e of death (Item | n 23a) (Type. | | | | | ,-/ | |
| | | | | ora M.D | | | | #209 51 | luer Sn | ring Mor | bae Iv | 20904 |

DHMH 16 Rev 6/95

State Registrar

State of Maryland / Department of Health and Mental Hygiene

97 27210

| | | | | | • | Cer | tifica | te of | Death | | Reg. No. | | |
|------------|--|-------------------|---|---|----------------------------------|-------------------------|-------------------------|----------------------|--|--------------------------------------|---------------------------|------------------------------|--|
| | 22. 11. | | 1. Decedent's Neme (First, Midd | le, Last) | | | | | | 2. Dete of D | eeth | V-1 | 3. Time of Death |
| | Physic /Medi | | Carolyn Anna M | farcelino | | | | | | Augus | t 15, 19 | Yeer 997 | 10:15 PM |
| | Exami | | 4e. Fecility Neme (If not institution | n, give street end n | um <i>ber)</i> | | | | 4b. City, Town, o | | | | |
| | | | Shady Grove Ad | ventist N | ursing | Center | | | Rockv | 111e | Mor | ntgome | rv |
| | Funeral | | 5. Social Security Number | 6. Sax | 7. Age (In yrs. | | | r 1 Yaar | If Undar 24 Hr | 8. Date of B | | | eca (Stete or Foreign |
| | Director | | 577-30-5921 | 1□M 2ŽŠF | 76 | Yrs. | Months | Deys | Hours Mir | March 2 | 2, 1921 | Penns | ylvania |
| | р. | | Usuel Residence of Decedant | | | | | | | | | | |
| | aryla ehov | - | 10a. State 10b. County | | 10c. Ci | ty, Town or Loc | | | | | | 10 | d. Inside City Limits |
| | 88-1 | 5 | | gomery | | Rockvi. | 11e | | | | | | 1 X Yes 2 No |
| | ith th | Die | 10e. Street end Number | | | | 10f. Zij | Code | | | 10g. Citizen of | What Count | ry? |
| | 72 hours efter death with the Maryland nature!', or items 23a or 28a-f show dical Examinet must be notified at | Funeral Director | 1616 Forbes S | Street | | | _ | | 1-1411 | | United | State | es |
| | er de | une | 11. Maritei Status | Armed F | | J,S. 13. W | Ves Dece Yes, spe | dent of h | dispenic Origin? (en, Maxicen, Pue | Specify Yes or N rto Ricen, etc.) | o- 14. Rea | ce - Americe ck, White, e | |
| 20 | or i | Y | 1 Never Married 2 Mar | If Yas, G | 2 🔯 No sive | | ☐ Yas | | | | Specif | | |
| 00 | ural. | d by | 3 ☐ Widowed 4 ☐ Divorced | | Detes: | | | | | | | Wh | ite |
| 21215-0020 | nat nat | Completed | 15. Deceder (Specify only highe | nt's Educetion Is <i>t grade completed</i> | 1) | 16e. Decede | ent's Usu kind of wo | al Occup ork done | oatlon during most of wi d) | orking | 16b. Kind of B | usiness/Indu | ustry |
| 12 | within ene. than | E D | Elementery/Secondery (0-12) | | (1-4or 5+) | | | | | | 0 | | |
| 7 | Hygie ther ther | ပိ | 17. Fether's Neme (First, Middle, | 3 | | Admin | ISTT | ativ | e Assist | | Govern G. Maidan Sumar | | Contractor |
| an | ould be filed with Mental Hygiene. arked other than atic event, the | Be | | | | | | | | | | 110) | |
| Maryland | should nd Men | 2 | William F. Zer | | | 405 14-75 | a water | (0) | | ret Dora | | 0 | |
| Ma | d 2 sho | | | | /1 1 | | | | and Number or F | | | | |
| | iges 1 and 2 should be filed within 72 hours effer death with the Marylar of Health and Mental Hygiene. If the start of the marked other than "natural", or items 23a or 28a-f show or other treumatic event, the Medical Examinet must be not find at | | Vincent Anthony 20e. Method of Disposition | Marcelli | no/nusbar | NO 1016 Place of Dispos | Forb | es S | street, | Rockvill | e, Maryl | | |
| O O | | | 1 X Buriel 2 ☐ Cremetion | | n State | cem <i>etery</i> , crem | etory or | other ple | ce) August 2 | 1, 1997 | Ess. Essentist | Only on Ton | , 0.0.0 |
| Baltimore, | rtani njun | | 4 Donetion 5 Other (S | | ма | ryland | Vete | rans | Cemeter | У | Chelten | ham, 1 | Maryland |
| Ba | permit. Page Department of Important: If any Injury or once. | | 21. Signature of Funerel Service | n h l | 20100 | | | | ess of Facility | neral Home | /Rockyri 11 | e. Inc | |
| _ | | _ | Marana you | Filme | Trau | 30 | 00 Wes | st Mo | ntgomery A | venue, Roo | kville, M | | 20850 – 280 |
| | | | 23e. Pert1. Enter the dueasa, o shock, or haart fill ura. List | complications thet only one ceusa on | ceused the deal aech lina. | th. Do not ente | r the mod | de of dyli | ng, such as cardi | ac or respiretory | errest, | | Approximete Intervat Between |
| | Physician | | American Course (Course) | | | | | | | | | | Onset and Death |
| | /Medical Examiner | | tmmediete Ceuse (Finel disaasa or condition resulting In deeth) | e Cirr | hosis | | | | | | | Y | ears |
| | | - | Trooping in account | | Due to (| or es a consequ | uence of) | | | | | | |
| | led lsit | nin | | b. Cere | brovasc | ular Ac | cide | nt | | | | Y | ears |
| _ | rificate be executed in graphysician and es the bunal-transit | Examiner | Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury | | Due to (d | or es e consequ | ence of): | | | | | | |
| 9 | be e lician bunis | | ceuse. Enter Underlying Ceuse (Diseese or Injury | _{c.} Diab | etes Me | | | | | | | Y | ears |
| 68760, | phys the | olbe | that initieted events rasulting in deeth) Last | 1 | Due to (d | or es a consequ | ence of): | | | | | | |
| × | certif ding | 1 | | d Hype | rtensio | n | | | | | | Y | ears |
| Box | that the death certificate be executed ed by the ettending physician and deteched for use as the bunat-transit | Physician/Medical | Date of the second | | | | | | | 1 | | | |
| 0 | t the d | hys | Part It. Other significant condition | one contributing to | death but not res | ulting in the un- | derlying | ceuse gn | en in Pert I. | | | | the cause of death? |
| ٦. | res thet igned b | by P | | | | | | | | . 'L | 1 108 2 NO | 3 Prob | ably 4 ⊠ Unknown |
| Records, | requires thet the een signed by th hould be deteche | | | | | | | | | | s an autopsy | 24b. Wer | e autopsy findings |
| 00 | v require been si should I | Completed | | | | | | | | perl | ormed? | com | leble prior to apletion of ceuse eath? |
| Be | The law ate has b page 2 s | Ē | | | | | | | | 45 | V 0 17 N- | | |
| Vital | | | 25. Wes cese referred to medica | 1 | | | | | 00 Di (D | | Yes 2 No | 10 | Yas 2⊠ No |
| > | | o Be | examiner? 1 ☐ Yes 2 ☒ No | Hospital: | Inpatient 2 | CD/Outpations | 2 D | Oth | 205 | eath (Check only | | (01) | |
| of | Phys rthis eral d | n: To | 27. Manner of Death | | of Injury of, Day Year) | 28b. Tima of | | 28c. Injui Woi | | | how Injury occur | | |
| O | th. Afte | tio | 1 ☑ Naturet 5 ☐ Pendir 2 ☐ Accident investi | | nth, Day Year) | Injury | M | | rk? Yas 2 □ No | | | | |
| Division | or Attending effer death. Director: Afte d in by the fune | fle | 3 ☐ Suicide 6 ☐ Could | inad 286. Plac | a of Injury - At h | ome, farm, stre | et, fector | y, office | | | (Street end Numi | ber or Rural | Route Number, |
| Ö | s efter | Certification: | 4 Homicide datam | bulk | ling, etc. (Specil | y) | | | | City or To | iwn, State) | | |
| | To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After thi completely filled in by the funeral | - 1 | 29e. Certifier 1 Certifyir | ng Physician: To th | a best of my kno | wiedga, daath | occurrad | at tha tir | me, date end pled | e, end due to the | ceuse(s) end m | annar as sta | ited. |
| | n 24 ne Fu pletet | edical | (Check only 2 Medicat one) | Examinar: On tha! | pasis of examina nnar stated. | tion and/or thva | astigation | , in my o | optnion, deeth occ | urred et the time | , data and plece, | and dua to t | tha cause(s) |
| | To the within 2 To the comple | × | 29b. Signeture end type Coulter | 2 | | | 29 | c. Licens | se number | | 29d. Date signe | ed (Month, D | ley, Year) |
| | 4 | | -401 | an | | | | D3 | 5792 | | August 1 | 6, 19 | 97 |
| | | | 30. Nema and eddress of person | wno completed ceu | ise of daeth (Itar | n 23a) (Type, P | Print) | | | 1 | 0 | , | |

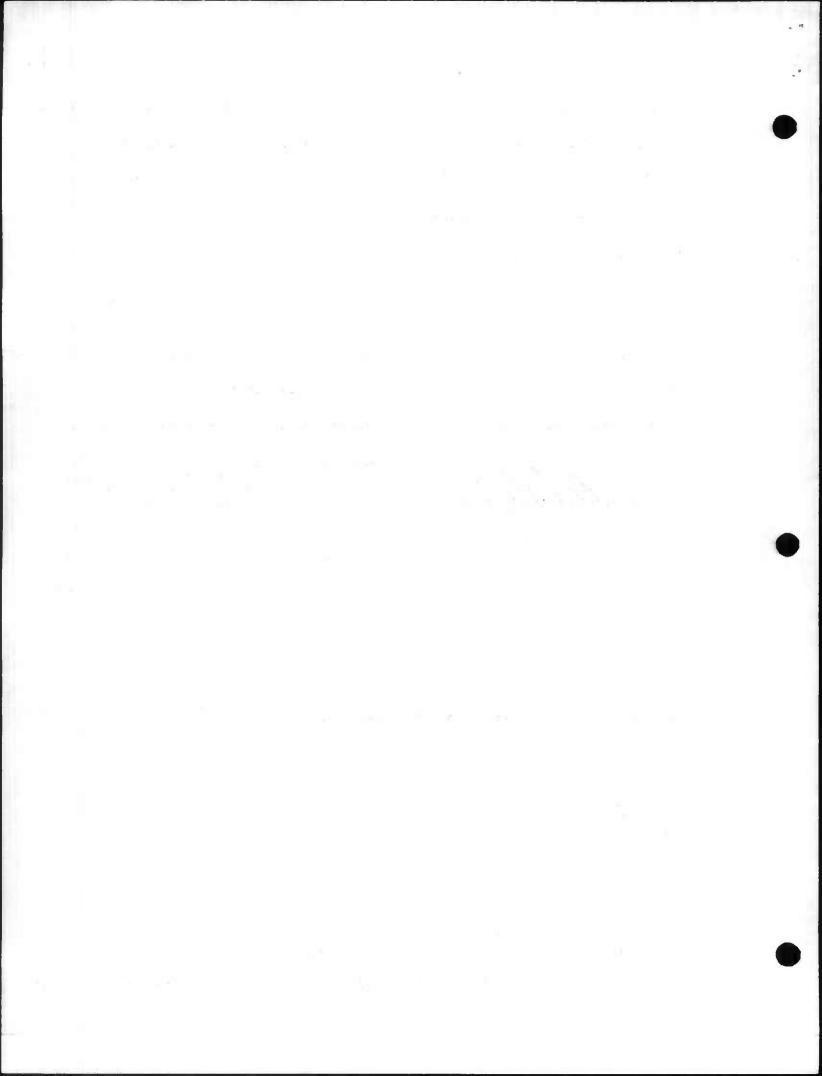
Swaroop G. Rao, M.D., 50 West Edmonston Drive, #504, Rockville, MD 20852-1228

Registrar

State

State of Maryland / Department of Health and Mental Hygiene

| | b | | | | | Cer | tificate o | f Death | | Reg. No. | - 1 | G 1 6 | a 1 1 |
|---------------------------------|---|-----------------|--|--|----------------------------------|-------------------|---|--|---|------------------------------------|------------------------------------|---|----------------|
| | Physic | an | Decedent's Neme (First, Middle, La | | | | | | 2. Deta of De Month | eth | Year | 3. Tima | of Deeth |
| | /Medi | | Dorothy I. Norw | | | | | | Aug | 24, 19 | 97 | 1:30 | P.M. |
| | Examir | ner | 4a. Facility Neme (If not institution, given | | | | | 4b. City, Town, or | Location ot Deeth | 4c. County | ot Death | | |
| L | | | 99 Charles St. A | | | | H Haday 1 Var | Westmins | | Carro | | | |
| | Funeral Director | | The state of the s | Sex 7. Ag 1□ M 24☐ F | e (In yrs. lest bi | rthday)_ Yrs. | Months Day | | . (Month, De | th y, Year) 20, 1929 | Coun | | or Foreign |
| | /land | | 10a. Stete 10b. County | | 10c. City, Tow | n or Loc | ation | | | | 1 | 0d. Inside (| City Limits |
| | se Man | Director | Maryland Carrol | 1 | Westmi | nste | r | | | | | 1 ☐ Ye | s 21 No |
| | ath with the 23a or 2 | ral Dire | 10e. Street end Number 99 Charles St. A | pt. A. | | | 10f. Zip Code 21157 | | | 10g. Citizen of 1 | | | |
| Baltimore, Maryland 21215-0020 | permit. Peges 1 and 2 should be filed within 72 hours aftar death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinal ment be notified at ance. | by Funeral | 11. Maritel Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced | 12. Wes Dacedant Armed Forcas? 1 Yes 2 H If Yes, Give Yaer or Detes: | | | /as Dacedent of Yes, specify Cu ☐ Yes 2 1 N | f HispenIc Orlgin? (: uban, Mexicen, Pue o <i>Specify:</i> | Specify Yes or No rto Rican, etc.) | - 14. Rec Ble Specifi | e - Americ ck, Whita, v: Wh: | atc. | |
| 5-0 | 72 h | Completed | 15. Decedent's E (Specify only highest gra | ducation ada com <i>pleted)</i> | 16e | Decade | ent's Usuel Occ | upetion e during most of wo | orking | 16b. Kind of B | usiness/inc | dustry | |
| 121 | vithin han " | mpf | Elementary/Secondery (0-12) | College (1-4or 5 | | | | red) | | | | | |
| 42 | Hygie ther t | | 7th 17. Fether's Neme (First, Middle, Last | 1 | C | usto | dian | 19 Mother's No | me (First, Middle, | Carroll | | ublic | Schoo |
| an | d be antal | o Be | Brice Runkles | , | | | | Zelma I | | Maiden Sullien | 10) | | |
| 37 | shoul nd Ma mark merk | F | 19e. Interment's Neme/Reletionship (| Type, Print) | 198 | o. Mailine | Address (Stre | et end Number or F | | er. City or Town. | Stete. Zio | Coda) | |
| Σ | alth a | | ANTO DE L'ON DE L'ANTO DE | aughter) | | | | Rd. Apt. | | | | | |
| e, | othe othe | | 20a. Method of Disposition | | 20b. Plece 0 | f Dispos | Ition (Neme of atory or other p | | Date | 20c. Location | | | ,, |
| Ē | Pege int: If | | 1 ☑ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specif | | | | Cemeter | | ig/28/19 | 97 Mt. | Airv. | . MD | |
| Balt | permit. Depertulmportal | | 21. Signeture of Funeral Servind Licer | 1/1/11 | 1 | | | rass ot Fecility By | rrier-Qu W. Old | een Fun Liberty | eral Rd. | Home | W- |
| | _ | | 23e. Pert1. Enter the disease, or come shock, or heart teilure. List only | plications thet caused | the death. Do | not ente | r the mode of d | | ield, MI | | T | Approxime | ete |
| e i | Physician | | Shock, of hooft tolidie. List only | One cause on eech in | 16. | | | | | | 1 | Intervel Be Onsat and | Deeth |
| | /Medical Examiner | | Immediete Ceuse (Finel diseese or condition | Acut | e Muoc | and | ial In | larctio | n | | | 1 h | n |
| | LAdminer | Ļ | resulting in deeth) | | Due to for es a | 0000000 | once of). | | | | | | |
| _ | ed isit | nlue | | b. Arte | rioscl | ero | tic he | eart dis | ease | | | 13 y | r |
| 68760, | infificate be executed ing physician and e es the burial-transit | edical Examiner | Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disaasa or injury that initiated events | C | Due to (or es e | | | | | | | | |
| Box 68 | certif ding | Σ | resulting In deeth) Last | d | Dua to (or es e | consequ | ence or): | | | | | | |
| Ö. | death a etta ed for | Physician/ | Part II. Other significent conditions of | ontributing to death bu | ıt not resulting i | n the und | derlying causa o | given in Pert I. | 23b. Dld 1 | lobacco une co | ntributa to | the cause | of death? |
| P. | es that tha death or igned by the ettand be datached for us | Phy | Chronic obstr | | | | | | 1× | Yee 2□ No | 3 Prot | oably 4 | Unknown |
| Division of Vital Records, P.O. | The law requires that the death ste been signed by the etter page 2 should be detached for u | Completed by | | | | | | | 24a. Wes perfo | en eutopsy rmed? | COL | ere eutopsy elieble prior mpletion of death? | to |
| ř | Tha la | E | | | | | | | 101 | res 2 No | 10 | Yes 2 |] No |
| Ta | delan: The cartificeta rector, peg | Be | 25. Wes case referred to medical | | | | | 26. Plece of De | eath (Check only o | , , , | | | |
| > | Physic this ca | T0 | exeminer? 1 ☐ Yes 2 No | Hospitel: 1 ☐ Inpatie | nt 2□ER/Ou | utpetient | 3□ DOA C | other: 4 - Nursing | Home 5 Rasio | dence 6 Oth | er (Specif) | y) | |
| sion o | To the Hospital or Attanding Physician: Tha i within 24 hours after death. To the Funeral Director: After this cardificeta he completely filled in by the funeral director, page | | 27. Menner of Deeth 1 Neturel 5 Pending 2 Accident investigation | | Year) 28b. | Time of Injury | 28c. Inj W M 1[| uryat ork? □ Yes 2 □ No | 28d. Describe i | now injury occur | red | | |
| DIV | al or Attu | Certification: | 3 Suicida 6 Could not b 4 Homlcide determined | e 28e. Place of Injubuilding, etc | iry - At home, fa . (Specify) | arm, strae | et, factory, office | 8 | 28t. Location (S City or Tov | Street end Numb vn, State) | er or Rura | l Routa Nui | n <i>ber</i> , |
| | To the Hospital or Attending I within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer | Medical | 29e. Cartifier (Check only one) 1 Cartifying Ph | ysician; To the best on inner: On the basis of end manner sta | examinetion en | a, deeth o | occurred et the estigetion, in my | time, date end plec opinion, deeth occ | e, end due to the urred et the time, | ceuse(s) end me dete end plece, | enner as st end due to | eted. the ceuse | (s) |
| | To the To the Comp | ž | 29b. Signeture and titla of certifier | 1 | | | 29c. Licar | nsa numbar | | 29d. Dete signe | d (Month, I | Dey, Yaer) | |
| | | | Meanewar | ui Ja | ac in | | DIL | 901 | | 8/25 | 19- | 7 | |
| | | | 30. Name and address of person who D. V. Faustino, | completed cause of de | eeth (Item 23e) L.Beck | (Type, P | rint) | | Box 698 | 8, Hamp | itea | d, Md2 | 21074 |
| | Sta Registr | | 31. Dete tiled (Month, Day, Yeer) AUG 2 6 19 | | | | | | , | | | | |



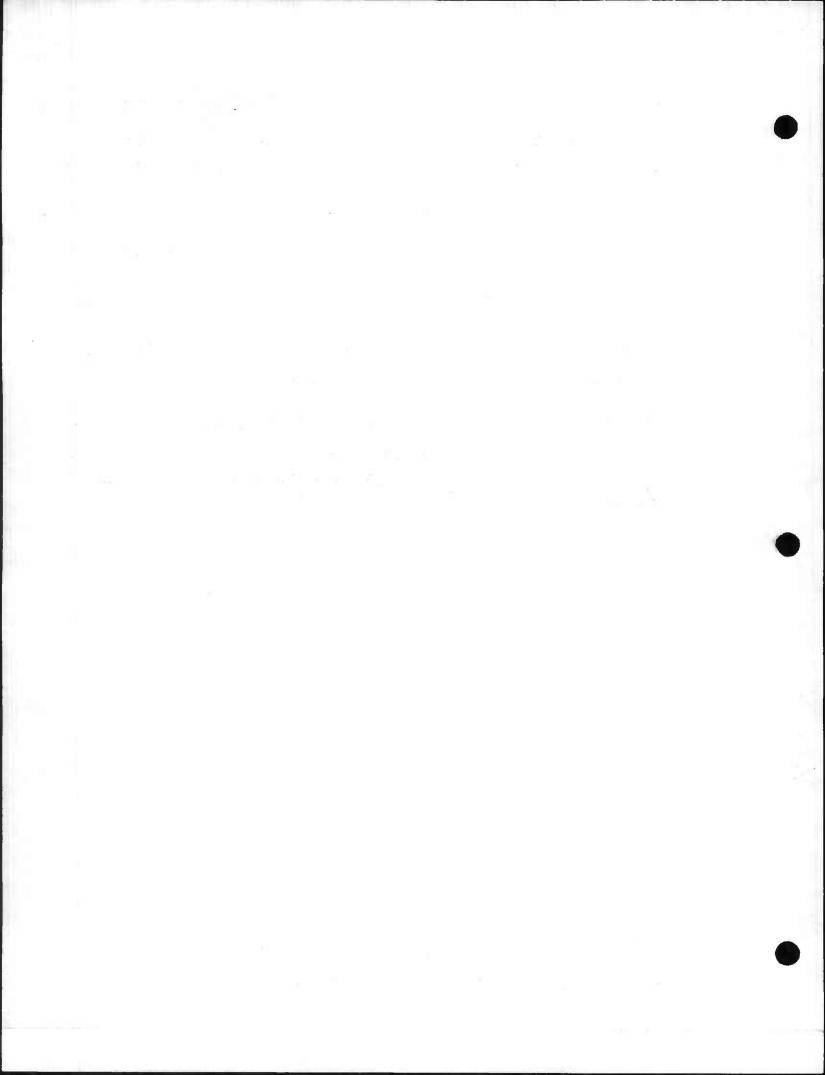
| | | | | | 1100001 | | | d / Depa | | Health and I | Mental Hy | | 7 2 | 27212 |
|------|--------------------------------|---|----------------|--|---|---|--------------------------------|--------------------------|--|---|------------------------------------|---------------------------------|-------------|--|
| | | Physic | ian | | Name (First, Middle, Last) | | | | | | 2. Date of De Month | Day | Year 997 | 3. Time of Death |
| 4 | | /Medi | cal | Vita | Nunning If not institution, give s | | nel . | | | 4b. City, Town, or I | August | | | 11:00 pm |
| | | Exami | ner | | MEMORIAL HO | | 91) | | | LA PLATA | LOCATION OF LIBERT | CHARLE | | |
| | | Funeral Director | | 5. Social Security N 124-14- | Number 6. Sex | | Age (In yrs. | lest birthday) 2 Yrs. | If Under 1 Yea Months Day | er If Under 24 Hrs. | 6. Date of Bir AMonth, De | 8 Year) 1925 | | ace (State or Foreign NY |
| | Ī | Meryland f ahow | tor | Usuai Residenca o 10e. State MD | 10b. County Charles | | 10c. City | y, Town or Loc arloti | ation te Hal | 1 | | | 10 | 0d. Inside City Limits 1 □ Yes 2 ▼No |
| | | h with the 23a or 28a at be noti | al Director | 10e. Street and Nu 7535 Po | mber plar St. | | | | 10f. Zip Code 206 | | | 10g. Citizen of W | | try? |
| | 20 | permit. Peges 1 end 2 should be filed within 72 hours after death with the Meryland Depertment of Heelth and Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ahow any fujury or other traumatic avent, the Medical Exeminer must be notified at once. | by Funeral | 11. Maritai Status 1 Navar Mari | riad 2 Married | 12. Was Deceda Armed Forca 1 Yes 2 If Yes, Give | s? No | lf. | Vas Decedant of Yas, spacify Cu □ Yes 20 N | f Hispanic Origin? (Suban, Maxican, Puart o Specify: | pecify Yas or No o Rican, atc.) | - 14. Raca Black Specify: | , Whita, e | an Indian, etc. |
| | 9 | hour | P P | 3 LI Widowed | 15. Decedent's Educ | Yaar or Date | s: | | | | | 16b. Kind of Bus | | |
| | Baltimore, Maryland 21215-0020 | ed within 72 giene. er than "na t the Med | Completed | Elementary/Second | cify only highast grade | Coilege (1-40 | or 5+) | life. C | ind of work don O NOT use reti omemak | * | king | | me | |
| | yland | ould be file Mental Hy arked oth atic avent | To Be (| 17. Father's Nama Rocco C | (First, Middle, Last) ataldo | | | | | | | Meiden Surnema a Catal | , | |
| | , Mar | end 2 sho eelth and m 27 is m | | Lemuel | ame/Relationship (Ty) J. Nunnii | ng/Hust | | 7535 | Popla | etend Number or Au r St. Ch | arlott | e Hall, | MD | 20622 |
| | limore | Peges 1 ment of H ant: If Itel ury or oth | | | position X Cremetion 3 □R 5 □ Other (Specify) | emovai from Sta | te Me | tropo | eltion (Name of elory or other p Litan | Crem. 8/ | 28/97 | Alexar | | |
| | Ball | Depending Import any Inj | | 21. Signature of Fi | unerai Service License | led | МО | | | TECHOLS ox 567 L | | | | C. |
| - | | Physician | | 23a. Part1. Enter 1 shock, or hee | the disease, or compiled the disease, or compiled the disease, or compiled the disease of the disease of the disease of the disease of the disease of the disease of the disease of the disease, or compiled the disease, or compiled the disease, or compiled the disease, or compiled the disease, or compiled the disease, or compiled the disease, or compiled the disease, or compiled the disease, or compiled the disease, or compiled the disease, or compiled the disease, or compiled the disease, or compiled the disease, or compiled the disease, | cations that cause on each | sed tha death | n. Do not ante | r tha moda of d | lying, such as cardiad | or respiratory a | rrest, | | Approximate Interval Between Onset and Death |
| | | /Medical Examiner | | Immediate Cause disease or condition resulting in death) | (Final on a | l | AS | p.12 | 100 | Preman | ia | | | Hous |
| | | | Ē | resulting in death) | | | Due to (o | r as a conseq | uence of): | | | | i | Yeus |
| | | uted d ansit | Examiner | Convention to link or | anditions b |). | Due to (o | r es a consequ | M Ar | toy D | sense | | i | Jaco 5 |
| 50. | 68760, | auth certificate be executed attending physician and for use es the buriel-transit | edicai Exa | Sequentially list co if any, leading to in cause. Enter Undo Cause (Disease or that initieted event resulting in death) | 3 | | Due to (o | Respi | mtunienca of): | tey D | icvera | 1 | i | Yews |
| アリカ | Box (| attending for use e | Physician/Me | | | l | | | | | | | | |
| Z | , P.O. | es that the de igned by the a be deteched i | by Physi | Part II. Other algni | ficant conditions con | tributing to deati | n but not res | uiting in the ur | derlying cause | given in Part t. | | | 3 Prot | the cause of death? |
| lita | Records, | e law requir hes been s je 2 should | Completed b | | | | | | | | perio | an autopsy ormed? | of o | pre autopsy findings allable prior to inpiation of causa death? |
| - | Vital | iclan: The la certificate he rector, pege | | 25. Was case refe | rred to medical | | | | | 26 Place of Dec | ath (Check only | | 1 | Yas 2 No |
| | Ę | yalcle is cert direct | To Be | axaminer? | / | lospitat: | atient 2 🗆 | ER/Outpatien | 3□ DOA | Where | | denca 6 □Othe | r (Specify |) |
| | Division of | anding Pheath. | | 27. Manner of Dea 1 ☑ Naturat 2 ☐ Accident | 5 Pending investigation | 28a. Date of I (Month, | njury Dey Year) | 28b. Time of Injury | 28c. In W | njuryat Vork? □ Yes 2 □ No | 28d. Describe | how injury occurre | ed | |
| | Divis | Ital or Attuins efter de al Directo | Certification: | 3 Suicide 4 Homicide | 6 Could not be determined | 28e. Piaca of building, | Injury - At he etc. (Specif | ome, farm, stre | et, factory, offic | SA. | 28f. Location (City or To | Street end Numbe wn, State) | or or Rure | I Route Number, |
| | | To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: After this certifica completely filled in by the funeral director, it | Medical | 29a. Certifier (Check only one) | 2 ☐ Medical Examin | | of examina | | estigation, in my | | | date and pleca, a | nd due to | the cause(s) |
| 4 | | To To a | 2 | 29b. Signature and | little of cartific | Jan | ~~ | 1 ms | |) 4047 9 | | 29d. Date signed | (Month, | Dey, Year) |
| | | | | 30. Name and add | ress of person who co | mpleted cause of | of death (Iten | 28a) (Type, | Print) | | | | | |

Robert Davison, Jr. 700 Old Line Center Stite 100 Waldorf, Maryland 20602
31. Date filed (Month, Dey, Yeer) 32. Registrar's Signature 32. Registrar's Signature

AUG 2 9 1997

State Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 22 Dey **Physician** Victoria Jolene Nietubicz /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 2217 Titan Terrace Havre de Grace Harford 5. Sociei Security Number If Under 1 Yeer If Under 24 Hrs. 6. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Deys Months Hours 1□M 25F Director 288-42-7142 50 Dec. 10, 1946 Ohio Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23s or 25s-f show other traumetic event, the Medical Examiner must be notified at Director Maryland Harford 1 Yes 200No Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2217 Titan Terrace 21078 U.S.A. permit. Peges 1 and 2 should be filed within 72 hours after death a Department of Health end Mental Hyghen. Important: if item 27 is marked other than "natural", or items 23s any injury or other traumette avant. Funeral 14. Race - American Indian, Black, White, etc. 11. Meritei Stetus 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 ☐ Never Merried 2X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedent'a Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Buainess/Industry College (1-4or 5+) Elamantary/Secondary (0-12) 12 Secretary Contractor 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Earl Butcher Myrtle G. Spegal 9 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Charles J. Nietubicz 2217 Titan Terrace, Havre de Grace, MD 21078 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1XXBurial 2 ☐ Cremation 3 ☐ Removal from Stata 4 □ Donation 5 □ Other (Specify) Baker Cemetery 8/26/97 Aberdeen, Maryland 21. Signeture of Falneral Service Licensee Tarring-Cargo Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each light. Aberdeen, Maryland 21001-3399 Approximata Interval Betw Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In deeth) Poorly differentiated carcinoma of Helung /Medical 6mos Examiner Examiner physician and the buriel-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): P.O. Box 68760. certificate be Physician/Medical Due to (or as a consequenca of): 88 attending 980 signed by the atte Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did lobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, à should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy periormed? Completed has 1 Yes 2 No 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No luneral (28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 28c. Injury at Work? 1 Matural 5 Pending 1 □ Yas 2 □ No investigation 2 Accident 6 Could not be detarmined 3 Sulcide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 26f. Location (Street end Number or Rurel Route Number, City or Town, Steta) filled in by 4 Homleide 29a. Certifier 1 Certifying Physician: To the best of my knowladge, death occurred at the time, data and place, and due to the causa(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner steled. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed ceuse of death (item 23a) (Type, Print) 10

Oncology Roo 1,32. Registrate Signature

V Room126

State Registrar

600 N. Wolfe St. 31. Dete flied (Month, Day, Year) AUG 2 5 1997

State of Maryland / Department of Health and Mental Hygiene 97

Phy: /Me Exa

Fune Direct

permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural", or items 23s or 28s-f show any Injury or other treumatic event, the Medical Examples investigated at

Baltimore, Maryland 21215-0020

Physicia /Medic Examin

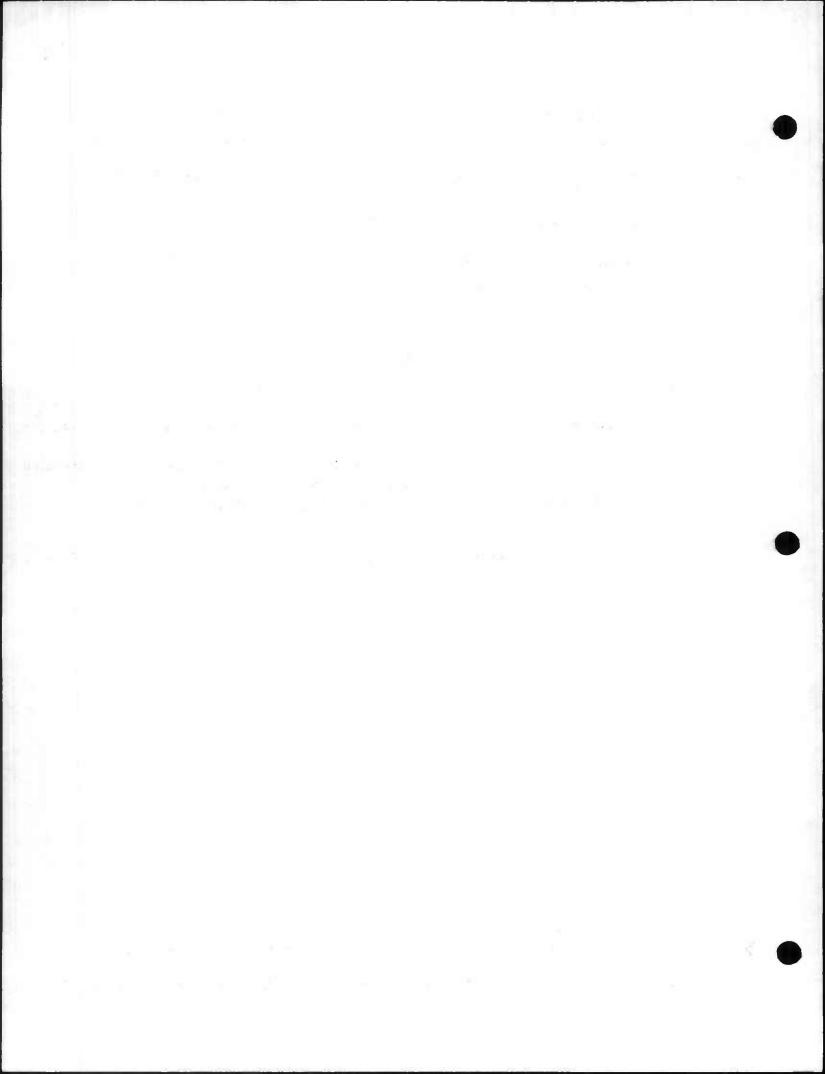
To the Hospital or Attending Physician: The law requires that the deeth certificate be executed the within 24 hours effer deeth.

To the Funeral Director: After this certificate has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit Division of Vital Records, P.O. Box 68760,

| | | | , | Cer | tificate | of Death | | Reg. No. | - No | |
|----------------|-----------|---|---|---|----------------------------------|---|------------------------------------|------------------|-------------|-------------------------------------|
| | | 1. Decedent's Name (First, Middle, Last) |) | | | | 2. Date of D | eeth | ., | 3. Time of Death |
| icia: dica | | Triet Ba Nguyen | | | | | Month O.S. | Dey 2.2 | Year | 22:45 |
| nine | | 4e. Facility Name (If not institution, give | street end number) | | | 4b. City, Town, o | r Location of Dee | T | y of Death | |
| | | 415 University Bo | oulevard, Ea | ast | | Silver S | pring | Mon | ntgom | erv |
| ai | | 5. Social Security Number 6. Sex | x 7. Age (In | yrs. lest birthday) | if Under 1 \ | | S. B. Date of B | | 9. Birth | place (Stete or Foreign |
| or: | | 217-33-8132 | M 2□ F 5(| 6 Yrs. | MOTHE | ays Hours Mil | March | 19,1941 | Viet | Nam |
| | <u>.</u> | 10a. State 10b. County | 100 | c. City, Town or Loc | eation | | | | | 10d. Inside City Limits |
| | Director | Maryland Montgomer | cy | Silver | Sprin | ng | | | | 1 ☐ Yes 2 No |
| 1 | Dire | 10e. Street end Number | | | 10f. Zip Co | ode | | 10g. Citizen of | Whet Cou | ntry? |
| | <u>a</u> | 415 University Bou | ılevard, Eas | st | 20 | 901 | | U.S.A | A. | |
| | Funeral | 11. Marital Status | 12. Wes Decedent Ever Armed Forces? | in U,S. 13. W | as Deceden Yes, specify | t of Hispanic Origin? (Cuban, Mexicen, Pue | (Specify Yes or Norto Rican, etc.) | o- 14. Ra Ble | ce - Ameri | cen Indian, |
| L | Z X | 1 Never Married 2 Married | 1 ☐ Yes 2 No If Yes, Give | | | No Specify: | | Specia | | |
| | d D | 3 Widowed 4 Divorced | Year or Dates: | | | | | - Open | As | ian |
| | Completed | 15. Decedent's Edui (Specify only highest grede | | 18e. Deced | ent's Usuel C aind of work of | eccupation done during most of w retired) | rorking | 16b. Kind of B | Business/In | ndustry |
| | E E | Elementery/Secondary (0-12) | College (1-4or 5+) | life. D | O NOT use r | retired) | | | | |
| 6 | S | 17. Fether's Name (First, Middle, Lest) | 2 | Capt | ain | 10 Mother's N | eme (First, Middle | | tary | |
| d | Q Q | | | | | To. Mother's No | erne (First, Middi | e, Merden Sumer | me) | |
| 1 | 0 | Tho Ba Nguyen | | 1 | | Cu | Thi Ngo | | | |
| | | 19a. Informent's Name/Reletionship (Type | pe, Print) | | | treet end Number or I | | | | |
| | | Dung Nguyen | 100 | 415 U | nivers | ity Boulev | | t Silver | Spr | ing, Marylan |
| | | 20e. Method of Disposition 1 Burlal 2 □ Cremetion 3 □ R | emovel from State | Ob. Plece of Dispos cemetery, crem | etory or othe | r plece) | Dete | 20c. Location | - City or T | own, Stete |
| | | 4 ☐ Donetion 5 ☐ Other (Specify) | | ate of He | aven | Cemetery | 8/26/97 | Silver | Sprin | ng,Maryland |
| SUCE. | | 21. Signature of Funeral Segrice License | 90 | 22. | Name and A | ddress of Fecility J. Collins | | | | 0,, |
| a | 3 | 2 rue D. Sce | wo | | | ersity Blv | | | | MD 20001 |
| | | 23e. Perti. Enter the disease, or compile shock, or heert failure. List only on | cations that caused the | death. Do not ente | r the mode o | f dying, such es cerdl | ac or respiratory | arrest, | r ring, | Approximate |
| n | | Shook, of heart failure. List only on | e ceuse on each line. | | | | | | | Intervel Between Onset and Death |
| al | | Immediate Cause (Finel disease or condition | Votactotic | Dwagtata | Como | | | | | 1 1/2 Yrs. |
| er | 1 | resulting In death) | Metastatic | to (or es e consequ | | LIIOIIIA | | | | I I/Z IIS. |
| | ē | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | | | |
| 1 | Cyamine | Sequentially list conditions. | Due | to (or es a consequ | ience of): | | | | | |
| | | Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury | | | | | | | | |
| Jodios | 2 | thet initiated events resulting in deeth) Last | Due 1 | to (or as e consequ | ence of): | | | | | |
| 1 | 2 | resulting in deeth) cast | | | | | | | į | |
| | | d | l | | | | | | | |
| Ohiologo | 2 | Part II. Other algnificant conditiona con- | tributing to death but not | t resulting in the un | deriving ceus | e given in Part I | 23b. Dic | I tobacco use co | ontribute t | o the cause of death? |
| Par de | | | | | , | | | Yes 2 No | 3 Pro | |
| 3 | | | | | | | - | X | | |
| Completed by | 2 | | | | | | | s en eutopsy | 24b. W | ere autopsy findings |
| 10 | | | | | | | pen | ormed? | CC | ompletion of ceuse deeth? |
| 1 | | | | | | | 10 | Yes 2 No | | Yes 2 No |
| 0 | 5 | 25. Wes case referred to medical | | | | 00 81 | | A | | LI Tes ZLI NO |
| 0 | | examiner? | lospitel: | a∏ 50/0 | •□ □ | Othor | eeth (Check only | | | <u> </u> |
| - 15 | - 1 | 1 ☐ Yes 2 ☐ No | | 2 ☐ ER/Outpatlent 28b. Time of | | | Home 5 Res | how injury occu | | (y) |
| 3 | 3 | 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation | 28a. Date of Injury (Month, Dey Yee | (r) Injury | м | Injury at Work? | | | | |
| 100 | 2 | 3 Suicide 6 Could not be | 28e. Place of Injury - / | At home farm stre | et fectory of | | 28f. Location | (Street end Num | ber or Run | el Route Number, |
| Cartification. | 2 | 4 ☐ Homicide determined | building, etc. (Sp | pecify) | 01,1001019,01 | | | own, Stete) | | |
| | | 29a, Certifier 153 Certifying Phys | icien: To the best of my | knowledge deeth | occurred at t | he time, date and plac | ce and due to the | ceuse(s) and m | annar as e | etatad |
| Madical | 2 | | ner: On the basis of exame and manner steted. | | | | | | | |
| N | 2 | 29b. Signeture end title of certifier | | | 29c. Li | cense number | | 29d. Dete signe | ed (Month. | Dey, Year) |
| | | 1/// | 1/20 | | | | | | | |
| | - | Jan 12. | | | _ | 38351 | | August | 23, 1 | .997 |
| | | 30. Name and address of person who con | | | | 72.0 11.0 | 10 0 | 1 1 | 4 | 1 00770 |
| | | Lucat D. Duckett, M | 1.D. /525 (| Greenway | Center | r Drive #2 | 13 Gree | noelt, M | aryla | na 20//0 |

32. Registrar's Signature

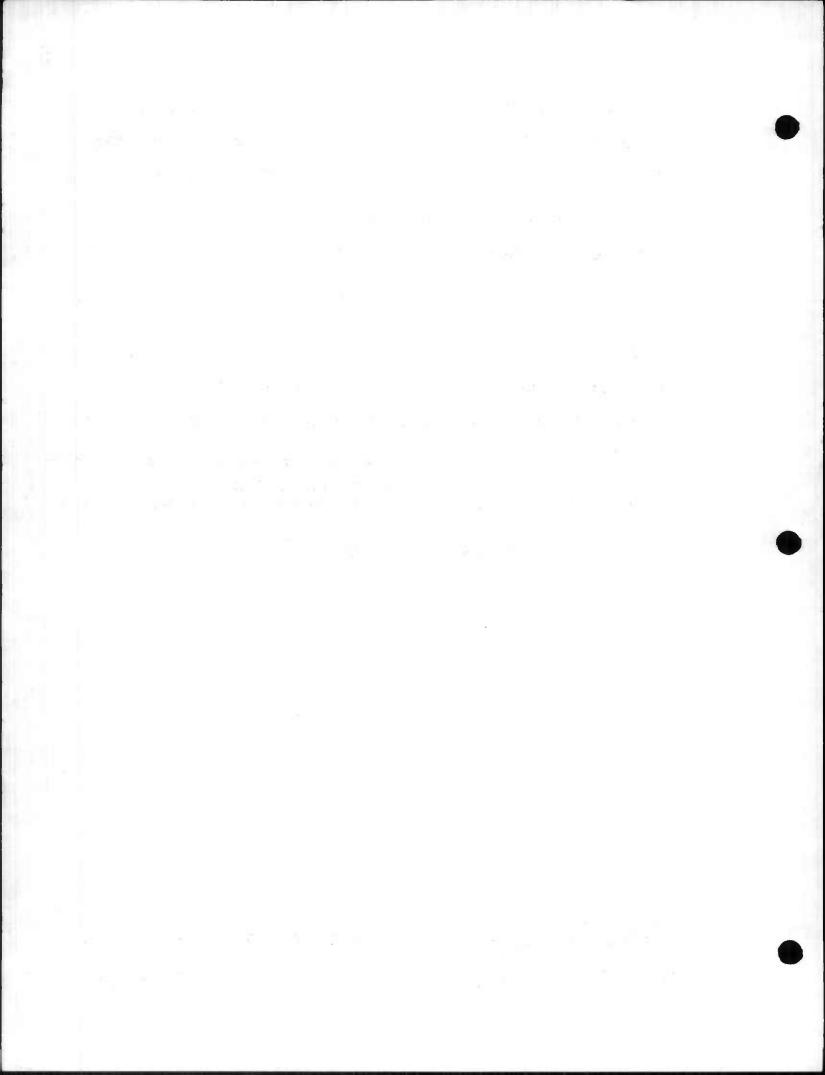
State Registrar



State of Maryland / Department of Health and Mental Hygiene 07 272 15

| | | | | | Certifica | | | | eg. No. | 1 6 | 1213 | | | | |
|--|------------------|--|--|---|---|--|---|---|---|---|---|--|--|--|--|
| Physi | cian | | Decedent's Nem <i>e (First, Middle, Last)</i> Amritha M. Nambiar | | | | | | ete of Deeth Onth Dey 1997 3. Time of De UST 21, 1997 12:45 | | | | | | |
| /Med | | 4e. Fecility Neme (If not institution, give | | | | 4b City Town or | August 2 | | 12:45 AM | | | | | | |
| Exam | iner | Holy Cross Hospi | | | | | | City, Town, or Location of Deeth Silver Spring Montgomery | | | | | | | |
| Funera Directo | | 5. Sociel Security Number 6. Se | 7. Age (In yrs. last birthdey) If Under 1 Y | | | | If Under 24 Hrs Hours Min 25 | 8. Dete of Birth | Year) | 9. Birthplece Country) | Sirthplece (State or Foreign Country) aryland | | | | |
| yland | | 10a. Stete 10b. County | | 10c. City, Town | or Location | | | | | 10d. | Inside City Limits | | | | |
| he Ma 8a-f e | ector | | | | | | | | | 1 ☐ Yes 2 | | | | | |
| ath with the 23a or 2 | Funeral Director | 17610 Silver Doll | | 10g. Citizen of Whet Country? United States | | | | | | | | | | | |
| 1020 Was after death with the Manyar al', or items 23s or 28s-f show Exeminer results to notified at | by Fune | 11. Maritel Status 1 1 Never Married 2 Merried 3 Widowed 4 Divorced | Ever in U,S. | | edent of Feeding Cub | dispenic Origin? (Sen, Mexican, Puer Specify: | Bied | 14. Rece - American Indian, Bieck, White, etc. Specify: Indian | | | | | | | |
| 15-0 72 hc | Completed | 15. Decedent's Ed (Specify only highest green Elamentery/Secondary (0-12) | ucation de <i>completed)</i> College (1-4or 5 | | 6e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Indus | | | | | | | | | | |
| d 2 filled v Hygie ther t | | 17. Fether's Neme (First, Middle, Last) | 0 None | | | | | | | None 's Name (First, Middle, Malden Sumame) | | | | | |
| Maryland 212: d 2 should be filed within th and Mental Hygiene. 7 is marked other than traumatic event, train | To Be | Madhusoodana Na | mbiar | | | | | i Madhusoodana | | | | | | | |
| Aary 2 shou and N is mar | | 19e. informent's Neme/Raiationship (7 | | | _ | , | | ural Route Number, | | | | | | | |
| 2 9525 | | Madhusoodana Nambi | ar Fa | | | | | ourt, Gait | | | | | | | |
| Baltimore, bemit. Peges 1 ar Department of Hea mportant: If Item 2 | | 20e. Method of Disposition 1 Buriel 2 Cremetion 3 | | 20b. Piace of I | | | | Dete 20c. Location - City or Town, Stete | | | | | | | |
| Baltimo pemit. Peges Department of Important: If It any injury or | | 4 □ Donetion 5 □ Other (Spacify) 21. Signature of Funerel Service License | · | Ches | apeake | | | | | lle, M | aryland | | | | |
| Ball permit. Depart Import any inj | | Co Co Co | | | | | | ices, P.A Silver Sp | | | nd 20910 | | | | |
| by Y60, tificate be executed Wedge as physician and as the buriat-transit | 1 | Immediate Cause (Final disease or condition resulting In death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avants resulting in death) Lest | b | Due to (or es e co | onsequence o | f): f): | it by | | | | | | | | |
| - 200 | | | d | | | | | | | | | | | | |
| death carl death carl e ettendin ed for use | siclar | Pert II. Other significent conditions co | 23b. Did to | 23b. Did tobacco use contribute to the cause of death? | | | | | | | | | | | |
| T.C. | by Physician/N | | , codda gir | | | 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknow | | | | | | | | | |
| 2 s € | Completed | | | performed? evel | | | eutopsy findings ble prior to etion of cause th? | | | | | | | | |
| - F # d | Son | | | | | | | | s 2 No | 1 □ Y | as 20 No | | | | |
| VICAL INSICIAN: The certificate irector, pag | o Be | 25. Wes cese referred to medical examiner? | Hospitel: Management of Documents of Documen | | | | | | | | | | | | |
| the side | - | 1 ☐ Yes 2 X No 27. Manner of Deeth | Pospitel: 1 1 Inpatient 2 EP/Outpetient 3 DOA Other: 4 Nursil 28a. Date of Injury (Month, Dey Year) 28b. Tima of Injury Work? | | | | | Home 5 ☐ Residance 6 ☐ Other (Specify) 28d. Describe how injury occurred | | | | | | | |
| DIVISION OF VICA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, | Certification: | 1 DNatural 5 Pending 2 Accident Invastigation 3 Suicide 6 Could not be 4 Homicide datarmined | k? Yes 2□No | 28f. Location (Streat and Number or Rurel Route Number, City or Town, Stete) | | | | | | | | | | | |
| spital or nours efte | ai Cert | building, etc. (Specify) City or Town, Stete) 29a. Cartiflar 1 \(\) \(\) \(\) Certifying Phyeician: To the bast of my knowladga, daath occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. | | | | | | | | | | | | | |
| he Ho in 24 I he Fui pletely | edicai | | | | | | | | | | ceusa(s) | | | | |
| To the To the Commercial Commerci | × | 29b Signature and tiller of certillier | b). Signature and little of certifier 29c. License D 3 | | | | | | | (Month, Dey, Year) | | | | | |
| | | 30. Nema and addrass of person who co | ompleted ceuse of de | 9300 (Item 23e) (T | ype, Print) | pora | te DR | Lan | dover | Md. | 20785 | | | | |
| Si | tate | 31. Date filed (Month Aug 2 5 1 | 997 32. Registr | ir's Signature | Rondon | 6 | | | | | | | | | |

DHMH 16 Rev 6/95



| | | | | | | State | of M | arylan | | artment of <i>rtificate o</i> | | lealth and I <i>Death</i> | Mental H | /giene Reg. No. | 9/ | 21 | 216 | |
|--------|---------------------------------|---|-----------------|---|---|------------|--------------|--------------|---------------------|----------------------------------|--------------------------|--|---|---------------------|-----------------------------|---|---------------------------------|--|
| | | Physici | an | Decedent's Neme (First, Middle, Last) | | | | | | | | 2. Date of Death Month Dey Yeer 3. Time of Deeth | | | | | | |
| | | Physici /Medic | | LESLIE EDWARD O'NIEL SR | | | | | | | | | August 27, 1997 5:00pm | | | | | |
| | 2 | Examir | ner | 4a. Facility Name | | | | | | | | b. City, Town, or | Location of Dea | | | inty of Death | | |
| | _ | | | Physicians Memorial Hospital 5. Social Sacurity Number 6. Sax 7. Aga (In yra | | | na (In vrs l | est birthday | If Under 1 Ye | | a Plata If Under 24 Hrs. | 8 Date of B | | arles | tholece / | State of Foreign | | |
| K | | Funerai Director | | 557-16-9 | | 1 M 2□ F | | | Yrs. | Months Dey | ys | Hours Min. | 8. Dete of B (Month, D NOV 21 | 1916 | C | 9. Birthplece (State or For Country) Virginia | | |
| | | | | Usual Rasidence | of Decedent | | | | | | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | | |
| | | permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland begins as \$100 permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland \$100 permit \$10 | - | 10e. Stete | 10b. County | | | 1 | , Town or L | ocation | | | | | | | side City Limits Yes 2□ No | |
| | | | Director | Maryland Charles Waldorf 10e. Street and Number 10g. Citize | | | | | | | | | | n of Whet C | | | | |
| | | | | 3042-B October Place 20601 | | | | | | | | | | USA | outility ! | | | |
| V | | | Funeral | 11. Maritei Stetus | i Stetus 12. Wes Decedent Ever in U, | | | | | | | ispenic Origin? (S in, Maxican, Puar | pecify Yas or N | | 14. Rece - American Indien, | | | |
| - | 0 | | F | 1 Never Mar | Armed Forces? Never Married 2 Married 1√7 Yes 2 No If Yes, Give | | | | | _ | | Specify: | Bieck, White, etc. Specify: White | | | | | |
| ā | 202 | | d by | 34 Widowed | 3 Wildowed 4 □ Divorcad If Yes, Give Year or Detes: | | | | | | | Specily. | | | | | | |
| > | 215-002 | | Completed | (Spe | 15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most of working the completed of the complete | | | | | | during most of wo | rking 16b. Kind of Business/Industry | | | | | | |
| - | 212 | | dwo | | Elamantary/Secondary (0-12) College (1-4or 5+) Truck Driver | | | | | | | | Delivery | | | | | |
| eshe C | b | | Be C | 17. Fether's Nama | | ast) | | | | | | 18. Mother's Ner | me (First, Middl | | | | | |
| | aryland | | To B | Grover C. O'Niel Mary E. Wo | | | | | | | • Wood | od O'Niel | | | | | | |
| | lan | | i : | 19a. Informent's N | | | | | | | | end Number or Ru | | | | Zip Code |) | |
| | e, M | | | James M. | | (Brothe | er) | not Di | | | - | d NE Pal | | T . | | 0 | | |
| | | | 36 | 20e. Method of Disposition 1 ☐ Burial 2 Acremetion 3 ☐ Removal from Stata 20b. Pleca of Disposition (Name of cametery, cremetory or other pleca) | | | | | | | Data | | | | | | | |
| -1 | altimor | | | 4 Donetion 5 Other (Specify) Metropolitan Crematory 8-29-97 21. Signature of Funeral Service Licensee 22. Name and Address of Facility | | | | | | | | Alexandra, VA | | | | | | |
| 7 | Ba | | | MO0173 J.H. Eberwein Mortuary | | | | | | | | | | | | | | |
| | | | | 4433 White Pls La White Pls., MD 20695 23a Parti. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate | | | | | | | | | | oximata | | | | |
| | | | | Anock, or heert feilure. List only one cause on each line. Interval Between Onset end Deeth | | | | | | | | | | | | | | |
| | 7 | | | Immediate Ceuse diseese or conditi | on | 10 | Co | ardi | 60 | Jail | 11 | rl. | | | | 1 | | |
| | н | | | rasulting In daath) Dua to (or es e consequanda of): | | | | | | | | | | | | | | |
| | | ate be axecuted hysician and the burial-transit | Examiner | - Sehaenic Cardio my opathy | | | | | | | | | | | | | | |
| | | | Exar | | | | | | | | | | | | | | | |
| | 8760, | hysicia the bur | dicail | | | | | | | | | | | | | | | |
| | 9 | ng ph | Med | resulting In death) | Lest | | | • | | , | | | | | | 1 | | |
| | Вох | eath certific ettending p | by Physician/Me | | ` | d | | | | | | | | | | 1 | | |
| | 0 | To the Hospital or Attending Physician: The law requiras that tha death certific within 24 hours aftar death. To the Funeral Director: After this certificate has been signed by the ettending prompletely filled in by the funeral director, page 2 should be detached for use es | ysic | Pert II. Other sign | Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? | | | | | | |
| | 9 | | / Ph | Severe Emphy Cema Respiratory | | | | | | | | 10 | 1 Yes 2 No 3 Probably 4 Unknown | | | | | |
| | rds | uiras n sign | | 1. 1/ | . 0 | P | 0 | | 1 | , | 1 | 00.00.1 | | s an eutopsy | 24b | Were et | utopsy findings | |
| | 000 | w require s been si | Completed | Jan un | re, | Reno | 21 | Ja | 1 Wi | 8C 4 | u | morrie | per | formed? | | | a prior to ion of cause ? | |
| | Division of Vital Records, P.O. | The law | | nephroschorodis Din Po Me & Vasula 2 10. | | | | | | | | | Yes 2 | Yes 2 No 1 Yes 2 No | | | | |
| | ita | delan: The certificate rector, pag | Bec | 25. Was date referred to medical Discontinuous 26. Placa of Death (Check only one) | | | | | | | | | | | | | | |
| | of V | ing Physician: After this certifica funeral director, p | 2 | 1 □ Yes 2 | (No | - | Inpati | | ER/Outpetie | III SLI DOA | Oth | 4 🗆 Nuising i | Homa 5□Re | | | ecity) | | |
| | n C | | | 27. Mengar of Dea | 5 Pending | | ete of Inju | ay Year) | 28b. Time of Injury | ١ ١ | | | 28d. Describ | e how injury o | occurred | | | |
| | Sign | death ctor: , | licat | Z Accident Investigation 3 Suicida 6 Colud not be determined 6 Colud not be determined 28a, Place of Injury - At homa, ferm, streat, factory, office 28f. Location (Street and Number or Rural Route Number, | | | | | | | | | | ta Number. | | | | |
| | Ö | aftar Direct | Certification: | 4 Homlcida datarmined | | | | | | | | | | | | | | |
| | | pspits hours uners ly fille | | 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, deta end plece, end due to the ceuse(s) and mannar as stated. | | | | | | | | | | | | | | |
| | | To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer | edical | (Check only one) 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, data and place, and dend mennar stated. | | | | | | | | | | | | | | |
| | | | | | | | | | 29d. Dete | signed (Month, Day, Year) | | | | | | | | |
| | | | | | 1/L | un | H | MARG | uno! | Lind | 12 | 2587 | | - 11 | | | | |
| | | | | 30. Nama and add | | | | | | | | | 6 14 | 1 1 00: | .00 | | | |
| | | Sta | ate | 31. Data filed (Mo | nth, Dey, Year) | eilia redi | Call U | enter, | _/=UP(tura •_ | OST UTILCE | ≥ K | Road, Waldo | ori, Mary | Land 200 | 002 | | | |
| | - | Registi | | | AUG 2 | 9 1997 | ₽ J | ula di | hucker | vardall | | | | | | | | |

Registrar

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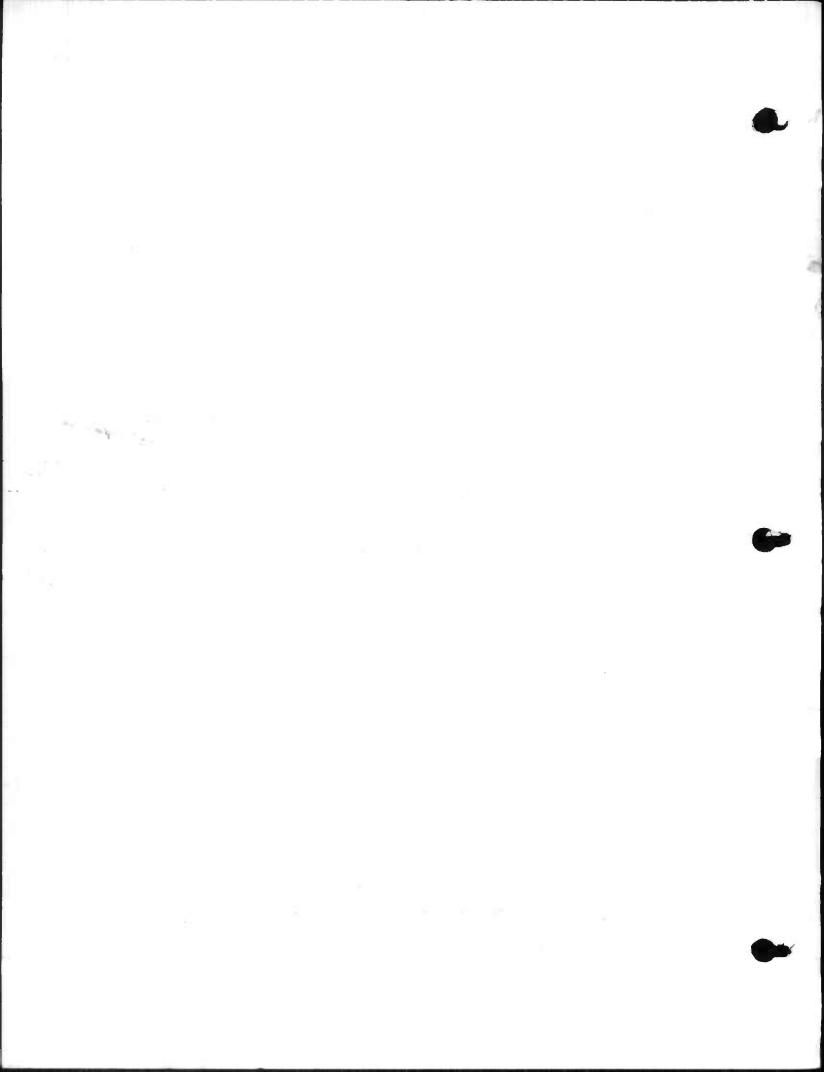
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within working the death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6

| DECEMPTION MANAGE PLANS MANAGE LAND VIVÍAIN ON CIZ OCH 1. SECRETARY MANAGE MA | 1 | FOR STATE REGISTRAR | STATE OF MARYLA | ND / DEPARTM CERTIFIC | MENT OF HEA | ALTH AND | | IYGIENE REG. NO. | | | |
|--|------------|--|--|---|--------------------------------|------------------|----------------------------|-----------------------------------|--------------------------------|--|--|
| SOLAR SCIENTY NAME (if not primition, give state) S. SEC. S. ADE (if yet later) Jan. 1, 3,1918 S. DOWN DOWN DOWN DOWN DOWN DOWN DOWN DOWN | () | | ch | | | | 2. DATE OF | DEATN | 9 9 7 | 3. TIME OF DEATH 2:30pm | |
| The Hebrew Home | | | | MOI | | | 7. DATE OF 8 (Month, De | BIRTN ly, Ybar) | 8. BIRTNP Country) | | |
| NOT THE CASE AND NUMBER 4615 N. Park Avenue #716 | OR | The Hebrew Home | et end number) | | | | | 9c. COL | JNTY OF DEA | | |
| NOT THE CASE AND NUMBER 4615 N. Park Avenue #716 | DIRECT | 10e. STATE 10b. COUNTY | omery | | 11/10/2012 | | | | 1. | IOd. INSIDE CITY LIMITS? IV YES 2 NO | |
| Type Security Se | ERAL | | enue #716 | | | | | | TIZEN OF WH | AT COUNTRY? | |
| 198. DECEDENTS EDUCATION 198. DECEDENTS SUBJUL OCCUPATION 198. ARMO OF BUSINESS MADUSTRY 198. ARMO (First, Modits, Matcher) 198. | | 1 Never Merried 2 Merried | FORCES? 1 YES | 2 X NO | If yes, specif | ly Cuben, Mexice | n, Puerto Ricar | | Black, | | |
| The Strauss No. MANY'S MAME (Type**Pix) 193. MALING ADDRESS (Street and Number of Pauls Robul Mance, City or Davis, Stein, Zio Code) Harris Orzach 10944 Hilltop La Columbia, MD 21044 10944 Hilltop La Columbia, MD 21044 10944 | PLETED | (Specify only highest grade co | College (1-4 or 5 +) | (Give kind of work life. Do NOT use re | done during most of tired.) | | | .C. Sch | OO 1 | | |
| THE PROPRIANT'S NAME (PyperPrint) 198. MALING ADDRESS (Street and Number or Paral Route Number, City or Town, Stein, Zip Code) Harris Orzach | | | man | nusic , | | 8. MOTNER'S NA | | le, Melden Surneme) | each | er | |
| No. METHOD OF DISPOSITION Name of No. METHOD OF DISPOSITION Name of No. METHOD OF DISPOSITION Name of No. METHOD OF DISPOSITION Name of No. METHOD OF DISPOSITION Name of No. METHOD OF DISPOSITION Name of No. METHOD OF DISPOSITION Name of No. METHOD OF DISPOSITION Name of No. METHOD OF DISPOSITION Name of No. METHOD OF DISPOSITION Name of No. METHOD OF DISPOSITION Name of No. METHOD OF DISPOSITION Name of No. METHOD OF DISPOSITION Name of No. METHOD OF DISPOSITION Name of No. METHOD OF DISPOSITION Name of No. METHOD OF DISPOSITION Name of No. METHOD OF DISPOSITION Name of | | 19a. INFORMANT'S NAME (Type/Print) | | | | Number or Rural | Route Number, C | City or Town, State, Zi | | 44 | |
| 23. PART I. Enter the diseasea, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or reapiratory arrest, above, or heart failure, List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in deeth) | | X Buriel 2 ☐ Cremetion 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify) | of from State cemet | LACE AND DATE OF D | ISPOSITION (Name | Gdns | 8 / 2 7 / | Falls | Chur | ch, VA | |
| IMMEDIATE CAUSE (Final disease or condition resulting in deeth) OUE TO (OR AS A CONSEQUENCE OF): | | 0 0 | - | | Ives-I 2847 V | Pearso Vilson | n Fun Blvd | eral Ho . Arlin | mes | , VA22201 | |
| PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Part I. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Part I. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Part I. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Part I. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Part I. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Part I. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Part I. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Part I. Other algnificant conditions contribution of part I. Part I. Other algnificant conditions contribution on part I. Part I. Other algnificant conditions contribution on part I. Part I. Other algnificant conditions contribution on part I. Part I. Other algnificant conditions in Part I. Part I. Other algnificant conditions in Part I. Part I. Other algnificant conditions in Part I. Part II. Other algnificant conditions in Part II. Part II. Other II. Other II. Other algnificant conditions in Part II. Part II. Other II. Other II. Other II. Other II. Other II. Other II. Other II. Other II. Other II. Other II. Other II. Other III. Other II. TIFICATION | snock, or heart feiture. List immediate CAUSE (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated events | re the diseases, or complications that caused the death. Do not enter the mode of dying k, or heart fellure. List only one cause on each line. SE (Final ition in the complete of the complet | | | | | | | Approximate interval Between Onset and Death | |
| Accident Suicide Sui | A | PART II. Other algnificant conditions | 4 SHD, | PVD | | | _ 10 | PERFORMED? | RMED? AMAILABLE PRI | | |
| Accident Suicide Sui | SICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 10SPITAL: | PLACE OF DEATH (C | Check only one) | | | | | | |
| 3 Suicide 4 Nomicide 5 Could not be determined 286. PLACE OF INJURY — At home, farm, street, factory, office 5 City or Town, Steet 290. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the bast of my knowledge, death occurred at the time, date end piece, end due to the cause(e) end menner ee stated. 29b. SIGNATURE AND ADDRESS OF REPSON WAS COMPLETED AND DOSS ST. 29c. LICENSE NUMBER 29d. DATE SIGNED (Mont) 29d. DATE SIGNED (MONT) 29d. DATE SIGNED (MONT) | | 27. MANNER OF DEATH 1 M Netural 5 Pending | 28e. DATE OF INJURY | 28b. TIME OF | 28c. INJURY WORK | Y AT | | | CURED | | |
| 296. SIGNATURE AND ADDRESS OF DEBRON WHO COMPLETED CAUSE OF CONTINUENCE OF THE PROPERTY OF THE | | 3 Suicide 8 Could not be | 28e. PLACE OF INJURY — building, etc. (Specify | At home, farm, stree | t, factory, office | | 281. LOCATIO City or To | N (Street end Numbe wn, Stete) | v or Rural Ros | ite Number, | |
| 296. SIGNATURE SAD ADDRESS OF DEBEND WHO COMPLETED CAUSE OF CONTINUENCE OF CONTIN | OMPLE | (Check only 1 CERTIFYING PNYSICIA | | | | | | | | and menner se stated, | |
| STEVEN LIDEAN LIDIMANITARE ARAD DOLL | O BE | Stenen | Fyson MD D05885 > | | | | | | DATE SIGNED (Month, Day, Year) | | |
| 31. DATE FILED (MONTH, Day, Year) 32. REGISTRAR'S SIGNATURE JUNE JAN'S AUG. 27 1997 32. REGISTRAR'S SIGNATURE JUNE JAN'S AUG | | STEVEN L | IPSON | 6121 | MONT | TROS | EL | 2000 | , Lo | EVILLE | |



State of Maryland / Department of Health and Mental Hygiene 97 272 | 8

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| alala | 1 | . Decedent's Name | (First, Middle | e, Last) | | | | | | 2. Date of Do | eath Day | Yeer 3 | . Time of Death |
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| weulcai caminer | 4 | a. Fecility Neme (If | not institution | | | | | | 4b. City, Town, | r Location of Deat | | ty of Death | 2.00 1111 |
| | п | 9015 Bra | dford 1 | Pood | | | | | 0.41 | | | | |
| neral | 5. | Social Security Nu | | 6. Sex | 7. Age (In | yrs. last birthda | W) If Und | der 1 Year | If Under 24 H | pring s. 8. Dete of Bi | mont | gomery | (State or Forei |
| ector | П | 578-09-5 | 216 | t M 2□ | F | Yrs. | Month | s Days | Hours M | n. (Montin, Di | ay, Year) | Country) | |
| , CtOi | U | Isual Residence of | | | 87 | | | | | Feb. 9 | ,1910_ | Pennsy | lvania |
| 16 | 1 | 0a. Stete | 10b. County | | 100 | City, Town or | Location | | | | | 10d. | Inside City Limit |
| eorga Examiner mast le notified at jeted by Funeral Director | ١. | | | | | | | | | | | | 1 ☐ Yes 2 🖾 N |
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| 늅 | | oe. Street and Num | 1001 | | | | 101. 2 | Zip Code | | | Tug. Citizen of | What Country? | |
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| Funeral | 1 | 1. Marital Status | | 12. Wes Arme | Decedent Ever od Forces? | in U,S. 13 | 3. Was Dec | pedent of H | lispenic Origin? | (Specify Yes or No erto Rican, etc.) |)- 14. Re | ace - American I eck, White, etc. | ndlan, |
| 匠 | | 1 Never Marrie | d 2 Marri | ed 1 □ Y | res 2 No s, Give | | | | Specify: | , | | | |
| by | | 3 ☐ Widowed 4 | 4 Divorced | Yeer | or Detes: | | 103 | 20110 | Specify. | | Spec | White | 2 |
| Completed | | /C===4 | 15. Decedent | 's Education | 40 | 16e. Dec | cedent's Us | sual Occup | etion | | 16b. Kind of | Business/Indust | |
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| O | 1 | 7. Father's Name (/ | First, Middle, I | | | Dake | u Goo | us se | | ame (First, Middle | | | |
| Be | | | | | | | | | | | , | | |
| 2 | | John | Orlets | | | | | | Sophi | a Unk | nown | | |
| | 1 | 9e. Informant's Nar | me/Reletionsh | nip (Type, Print) |) | 19b. Ma | iling Addre | ess (Street | e <i>nd N</i> um <i>ber</i> or | Rural Route Numb | er, City or Town | n, Stete, Zip Co | de) |
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| | 20 | De. Method of Dispo | | | | b. Plece of Disposerry, cr | position (N | veme of | ce) | Date | 20c. Location | - City or Town, | Stete |
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| once. | 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Facility Francis J. Collins Funeral Ho | | | | | | | | | | | | |
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| | 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resshock, or heart failure. List only one gause on each line. | | | | | | | dW S1 | lver Sp | - Ap | proximate | | |
| an | 2 | | e disease, or a failure. List of | complications the | hat caused the on each line. | WCC 5 | 00 Un | ivers | sity Bly | dW S1 | lver Sp | Ap | 20901 proximate erval Between set and Death |
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year George F. O'Malley August 18, 1997 5:55 M 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Lavhill Center Silver Spring Montgomery If Under 1 Yaar | If Under 24 Hrs. 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplaca (Stete or Foreign Country) Days Hours 1⊠M 2□ F Yrs. 320-34-5448 88 Illinois Usual Residenca of Dacedant 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Silver Spring 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Coda 10g, Citizen of What Country? 3227 Bel Pre Road 20906 United States 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∑Yes 2 No If Yes, Give Yaar or Detes: 1942-1971 1 □ Never Married 2 N Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced White 15. Decadent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 18b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 5+ Attorney Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Surname) George O'Malley Mary K. McIntyre 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Coda) James P. O'Malley/Son 73460 Feather Trail, Palm Desert, California 92260 20b. Place of Disposition (Name of cemetery, crematory or other pleceAug. 27, 1997 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery Arlington, Virginia Bethesda-Chevy Chase, Inc. R21 Name and Address of Facility 757 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee M00198 23a. Part1. Enter the durrase, or complications that causad the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or haart furner. List only one causa on each line. Approximate Intarval Betw Onset and Death Immediata Causa (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequenca of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No 25. Was case refarred to madical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Othar (Specify) Hospital: 1 Yes 2 No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No invastigation 6 Could not be datarmined 28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 1 Certifying Phyafcian: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and placa, and dua to the causa(s) and manner stated. 29b. Signature and titla of certifier 29d. Data signed (Month, Dey, Year)

3503 Perry Street, Mt. Ranier, Maryland

Randelle

20712

Physician /Medical Examiner the death certificate be executed Division of Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Examiner

Physician/Medical

by

Completed

Certification:

Medical

1 Natural

2 Accident

3 Sulcide

29a. Certifier

4 - Homicide

(Check only one)

Suresh C. Gupta, M.D.

31. Date filed (Month, Day 105) 2 9 1997

30. Nama and address of person who complated causa of daath (itam 23a) (Type, Print)

32. Registrar's Signatura

Julia Davidson

Funeral

Director

Show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiens. Immortant: If term 27 is marked other than "naturat", or items 23a or 28a-1 show eny Injury or other traumatic event, its Asolical Examines in mail be notified a

Baltimore, Maryland 21215-0020

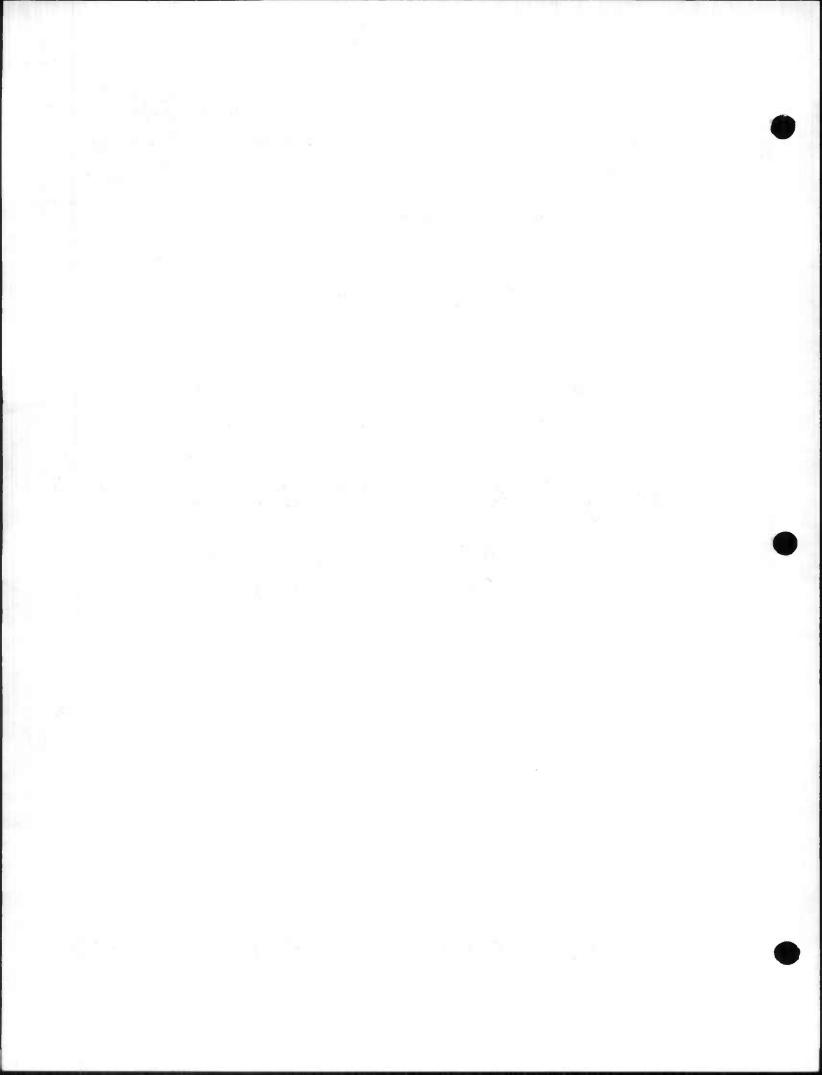
death with the Maryland

physician and s the burial-transit 98 USB signed by the a peen this certificate Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica funeral

To the Within 2 5+1

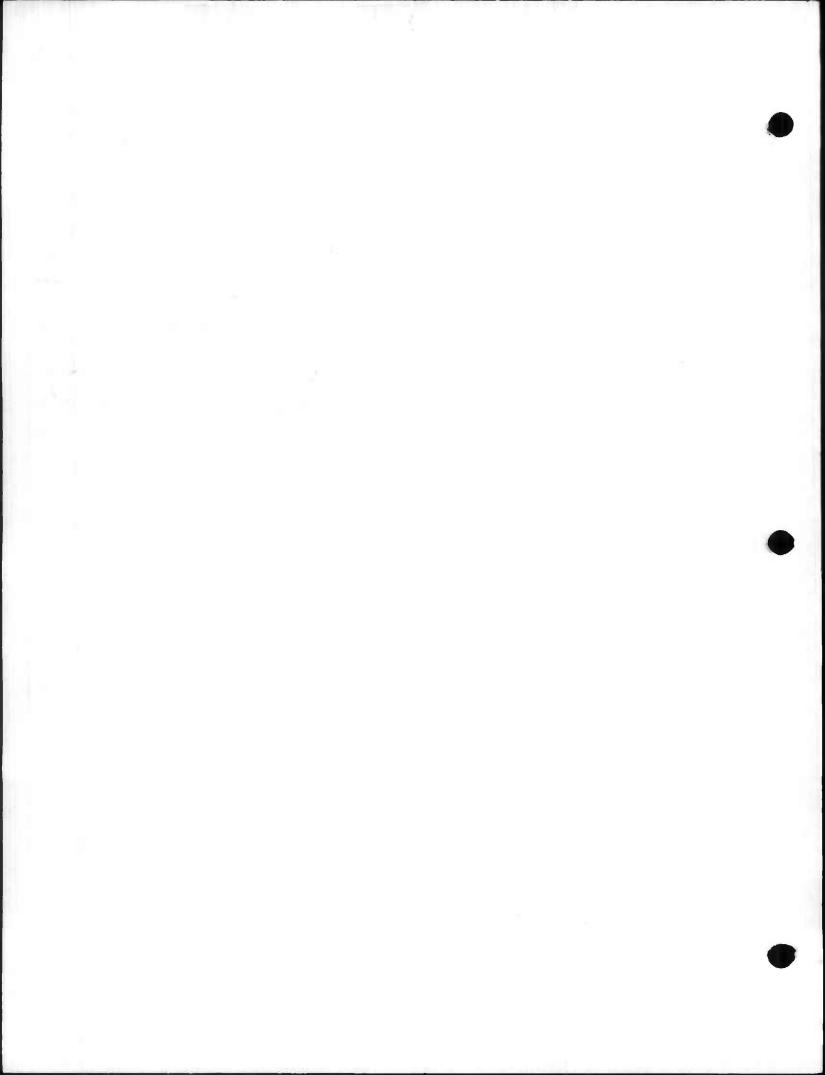
State

completaly



| THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a construction of the forest of the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should within 72 hours after death with the State Dept. of Health and Mental Hyghene prior to burial, cremation, or removal. **PORTANT: It item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be netfilled at once. |
|--|
|--|

| | FOR STATE REGISTRAR | STATE OF MARY | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | | |
|---------------|--|--|---|--|---------------------------------------|---|--|--|--|--|--|
| ! | 1. OECEDENT'S NAME (First, Middle, Last) | c- 1 | OWELL | . , | | 2. DATE OF OEATH MONTH D. ALLY 2 | | 3. TIME OF OEATH | | | |
| | 4. SOCIAL SECURITY NUMBER 225-32-8430 | 5. SEX 6. AG | E (In yrs. last birthday) 100 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. OATE OF BIRTH (Month, Day, Year) 06-29-189 | 8. BH | RTHPLACE (State or Foreign unitry) | | | |
| OR | | ursing Home | e | | e de Gra | | 9c. COUNTY OF | arford | | | |
| DIRECTOR | PRESIDENCE OF DECEDENT 10a. STATE 10b. COUNT | Harford | 10c. CI | TY, TOWN OR LOCAL | rion perdeen | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO | | | |
| | 100. STREET AND NUMBER 114 Post | | | | 1. ZIP COOE 210 | 0.1 | HILL TO THE OWNER OF THE OWNER OF THE OWNER OF THE OWNER OF THE OWNER OF THE OWNER OF THE OWNER OF THE OWNER OWNER OF THE OWNER OWNE | F WHAT COUNTRY? | | | |
| BY FUNERAL | 11. MARITAL STATUS 1 Never Married 2 Married 3 X Widowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR | S 2 NO | If yes, sp | CENCENT OF NISPAL | NIC ORIGIN? (Specify Year, Puerto Ricen, etc.) | s or No 14. R | ACE — American Indian, lisck, White, atc. pecify: | | | |
| COMPLETED | 15. OECEDENT'S EOI (Specify only highest grad Elementary/Secondary (0-12) | JCATION e completed) College (1-4 or 5+) | (Give kind of | s usual occupati I work done during me use retired.) | ost of working | 16b. KINO OF BU | SINESS/INOUSTR | γ | | | |
| BE COM | 17. FATNER'S NAME (First, Middle, Last) | e H. Clemer | | omemake | | ME (First, Middle, Meiden Hester | Home Meldon Surname) ter Napier | | | | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) Ms. Jeaune Klein | sorgen | | | Route Number, City or Tow deen, MD | 21001 | | | | | |
| | 20a. METHOD OF DISPOSITION 1 X Buriel 2 Cremetion 3 Rer 4 Donation 6 Other (Specify) | noval from Stata | PLACE OF OISP other place) Fairvie | w Cemet | ery | C | patesvil | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE L | ICENSEE | A. | Mitc Hav | hell-Smi re de Gi | th Funeral race, MD | Home, 21078-3 | P.A. 3197 | | | |
| 7 | 23. PART I. Enter the diseases, or shock, or heart fellure IMMEDIATE CAUSE (Final disease or condition resulting in death) | . List only one cause or | each lina. | Actory | | | oliretory arreat, | Approximate interval Batween Onset and Death | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | c | S A CONSEQUENCE | | | | | | | | |
| MEDICAL | PART II. Other algorificant conditions of the co | e Pe | ty have accused | y vas | | | RMED? | 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF CEATH? 1 YES 2 NO | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | 26. I | PLACE OF DEATH (C | heck only one) | | | | | |
| łYSI | 1 TYES 2 DIG | 1 🗆 Inpatient 2 🗆 ER/0 | | 4 Muraing No | ma 5 Residence | 6 Other (Specify) 28d. DESCRIBE NOW | INJURY OCCURE | 0 | | | |
| ВУ Р | 1 Pending 2 Accident Investigation | (Month, Day, Yer | | INJURY W | YES 2 NO | | | | | | |
| 6 | 3 Suicide 6 Could not be 4 Homicide determined | 28s. PLACE OF INJ building, etc. (3 | URY — At home, fam Specify) | n, street, factory, off | ice | 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| COMPLET | Check only | SICIAN: To the best of my lo | | | | | | use(s) and manner as stated. | | | |
| BE | 296. SIGNATURE AND TITLE OF CERTIF | - M | D | | D32 | JMBER G09 | 29d. DATE SIG | COSCIONED (Morith, Only, Year) | | | |
| 70 | 80. NAME AND ADDRESS OF PERSON V | rutiam . | DEATH (ITEM 27) (7) | 3 Revo | lutions | St-Hars | e De C | grace HISRID? | | | |
| | 31. DATE FILED (Month, Day, Year) ALLG 2.6 19 | 32. RINGISTRAR'S S | HONATURE RANGE | Ц | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Dev **Physician** Month Toney Reginal Pearson 1997 11:59 A.M. August 19, /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Manor Care Wheaton Wheaton Montgomery 5. Sociel Security Number If Under 1 Yaar | If Undar 24 Hrs. 8. Dete of Birth (Month, Day, Year)
April 18, 1958 North Carolina 7. Age (In yrs. last birthdey) **Funeral** 1 XM 2 ☐ F Devs Hours Yrs. Director 238-02-3337 39 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland work of Health and Mantal Hygiene. 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at MD Montgomery Silver Spring Yes 2 No Director 10e. Streat and Number 10f. Zip Code 10g. Citizen of Whet Country? 109 Croydon Court 20901 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Bieck White atc 1 Never Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: **Black** þ 3 ☐ Widowed 4 ☐ Divorcad Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Clerk Supermarket Business 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be Loveless Pearson Clara Prince 19e. informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Melody Allen Wife 109 Croydon Court, Silver Spring, MD 20901 other 1 20a. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, Stete permit. Pages Department of Important: If it any injury or once. 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from State Mount Comfort Crematory 8/23/97 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Fecility Joseph Gawler's Sons, Inc. 5130 WI Avenue, N.W., Washington, DC 20016 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, to have tellure. Let only one cause on each line. Approximete Intervel Betw Onset end Death **Physician** /Medical Immediate Ceuse (Final Respiratory Failure 2 Days disaesa or condition resulting in death) **Examiner** Due to (or es e consequenca of): Examiner Atelectasis, Consolidation 2 Weeks Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and physician and s the bunal-transit Sequentially list conditions, if eny, leeding to immediate causa. Enter Underlying Cause (Disease or Injury Due to (or es e consequence of) Box 68760. Small Cell Cancer Of Lung 6 Months Physician/Medical thet initieted events resulting in death) Last Due to (or as a consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Acquired Immunodeficiency Syndrome Completed by 24b. Were autopsy tindings available prior to completion of cause of deeth? HIV Infection 24a. Was an eutopsy performed? this certificate 2 No 1 Yes 2 No director, 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify, Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending 1 Neturel 1 TYes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, ferm, straet, fectory, offica building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the ceuse(s) and menner es stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. Medical

Division of Vital Records, P.O. To the Hospital or Atterwithin 24 hours after der To the Funeral Director completaly filled in by th

> State Registrar

29b. Signature end title of certifier

2000 Dennis Avenue, Silver Spring MD 20910 Katherine Waldmann, M.D. 32. Registrar's Signature wha Davidson

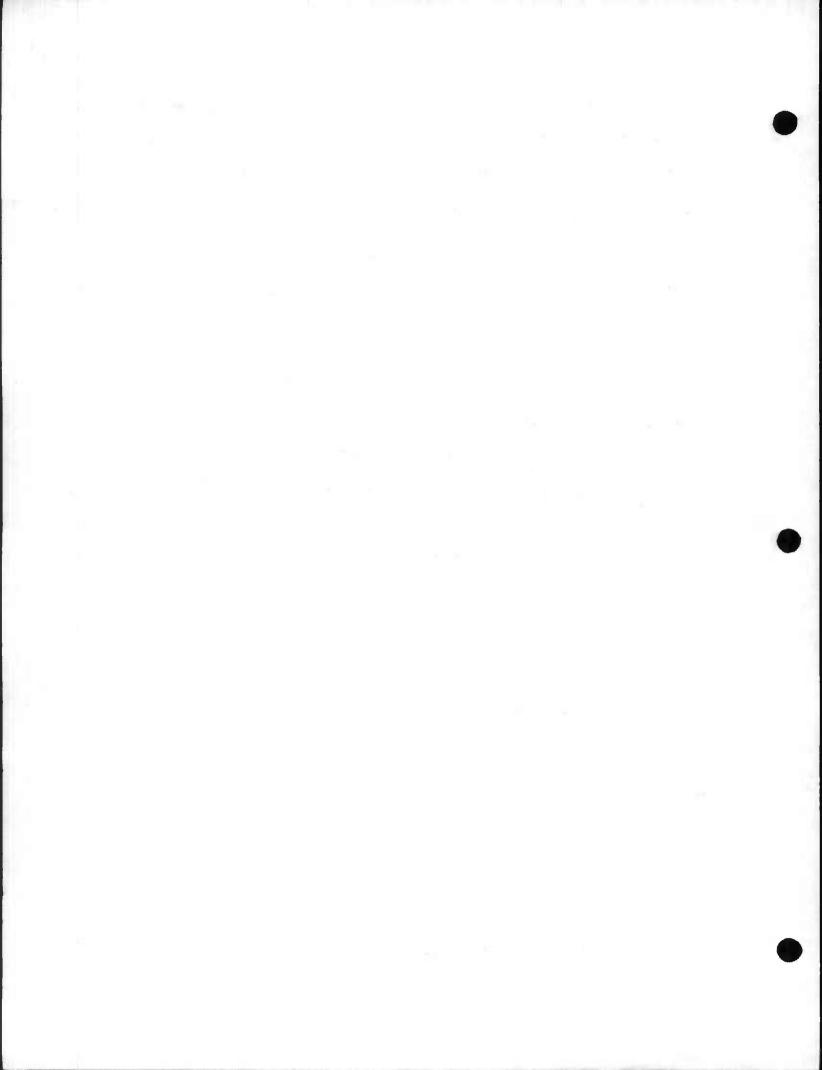
ine addurcon, M. D

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print)

29c. Licanse number

29d. Date signed (Month, Day, Year)

Cius. 20, 199

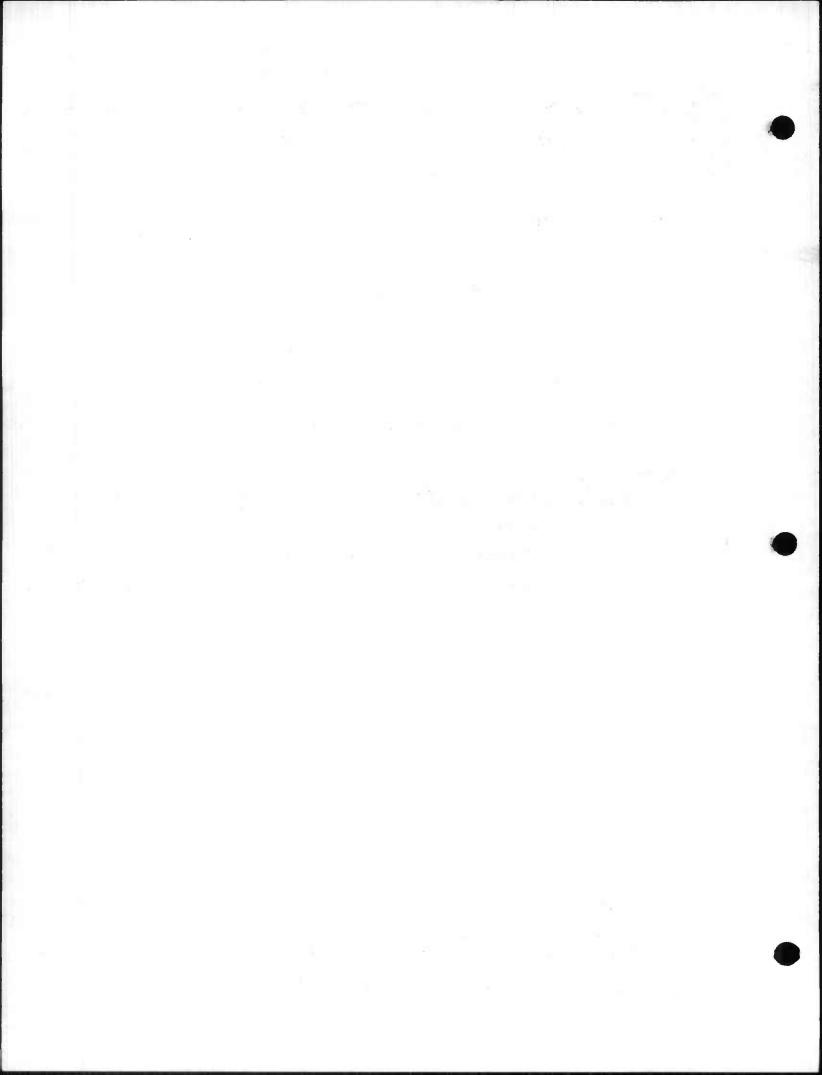


State of Maryland / Department of Health and Mental Hygiene 97 27222

Certificate of Death

| | | | | | Cen | tificate | of Death | | Reg. No. | | | |
|--|------------------|--|---|-----------------------|--------------------|--------------------------|---|--|-------------------------------|--|---|--|
| Dhuaisi | | 1. Decedent's Neme (First, Middle, L. | ast) | | | | | 2. Date of De | | Veer | 3. Time of Deeth | |
| Physicia /Medic | | EDMUND | Ò | 1 | 05 | TIC | 30 | AUG | 23 | 97 | 112/AN | |
| Examin | | 4e. Facility Name (If not institution, gi | ve street end number) | | | | 4b. City, Town, o | or Location of Deat | h 4c. Count | y of Death | | |
| | | Suburban Hospi | tal | | | | Bethes | | Mon. | tgome | ry | |
| Funeral Director | | | Sex 7. Ag | e (In yrs. lest 51 | birthdey)_ Yrs. | If Under 1 Y Months D | ear If Under 24 H ays Hours M | | th ey, Year) 8,1945 | 9. Birthpl Count BOL | lace (Stete or Foreign try) | |
| pu . | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, T | our or Loo | ation | | | | | 04 1 14 00 11 1 | |
| with the Maryland a or 28a-f show | ۲ | | 4 | Toc. Cay, 1 | | | | | | 10 | 0d. inside City Limits 1 ☐,Yes 2 ☐ No | |
| 10e Mary 728a-fah notified | ect | Virginia Arling | lon | | N/A | 1 | | 1 | | | X | |
| 23a or 3 | Funeral Director | 10e. Street end Number 811 North Florid | a Street | | | 10f. Zip Co | | | 10g. Chizen of Bolis | | 1ry7 | |
| hours effer death ural, or items 23 al Examinen must | þ | 11. Maritel Stetus 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced | 12. Was Decedent Armed Forces? 1 Yes 2 4 If Yes, Give Year or Dates: | | | | of Hispanic Origin? Cuban, Mexican, Pu No Specify: Bo | | | ce - America ck, White, e y: White | etc. | |
| natur scal | Completed | 15. Decedent's E | ducation | 1 | 6a. Decede | ent's Usual O | ccupation | | 16b. Kind of B | lusiness/Ind | lustry | |
| Bo " | ple | (Specify only highest gr Elementary/Secondary (0-12) | eae com <i>pletea)</i> College (1-4or 5 | 5+) | life. D | O NOT use re | one during most of waterd) | vorking | | | | |
| die die die die die die die die die die | 8 | 12' | | | Co | ncrete | Worker | | Constr | uctio | n | |
| tal Hygi d other event, t | Be | 17. Fether's Neme (First, Middle, Las | 1) | | | | 18. Mother's N | lame (First, Middle | , Meiden Sumer | ne) | | |
| | P | Eliodoro Postigo | | | | | Maria | Luisa Va | llejos | | | |
| h and Mer 7 is marke traumatic | | 19a. informant's Name/Relationship | (Type, Print) | 1 | 9b. Mailing | Address (St | reet end Number or | Rurel Route Numb | er, City or Town | , Stete, Zip | Code) | |
| alth 27 br tre | | Jacqueline Posti | go - Daugh | ter . | 811 N | . Flor | ida St. | Arlington, Va. 22205 Date 20c. Location - City or Town, State | | | | |
| nt of Health t: If item 27 y or other t | | 20a. Method of Disposition 1 ☐ Buriai 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci | | Deline | stery, crem | etory or other Cente | piece) | Date Aug. 28, | | | | |
| Department of Important: If it any injury or once. | ı | 21. Signature of Funeral Statice Liga | D900 | ddress of Facility | nag. 20, | 1777 Cha | inixe | .y, va. | | | | |
| permit. Departm Importar any inju | | 150 II | alle | Q CF | | | J. Murphy | Funeral | Home, -A | rling | ton, Va. | |
| Physician | | 23a. Part1. Enter the disease, or con shock, or heart failure. List only | plications that caused one cause on each li | I the death. D | o not ente | r the mode of | dylng, such es card | liac or respiretory a | rrest, | | Approximate Interval Between Onset and Death | |
| /Medical | -1 | Immediate Cause (Final disease or condition | MVaa | do Di | 11 | 11 | 1 FART | -(n) | | 1 | KUTE | |
| Examiner | | resulting in deeth) | 11/00, | Due to (or as | a consequ | ience of): | 1111001 | 100 | 6 | | | |
| n = | ner | | MYOC. | rock | EPT | 70 (| wandas | 011140 | Dice | Ac | XX RS | |
| physician and s the buriel-transit | Examiner | Sequentially list conditions, | b | Due to (or as | a consequ | ience of): | MUVIP | CUANK | Chel | V-6 | | |
| nding physician a | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury | | | | | | | | | | |
| ysic he bi | edicai | that initiated events resulting in death) Last | C | Due to (or as | a consequ | ence of): | | | | | | |
| 0.6 | ≅ | resulting in deathy East | d | | | | | | | | | |
| | Physician/ | | | | | | | | | | | |
| 0 2 | Ysi | Part ii. Other significant conditions | contributing to death be | ut not resulting | g in the und | derlying caus | e given in Part i. | 23b. Did | tobacco use co | entributa to | the cause of death? | |
| | by Ph | | | | | | | 10 | Yes 2□No | 3 Prob | bably 47 Unknown | |
| has been signed by the | Completed | | | | | | | | an autopsy ormed? | con | ere autopsy findings aliable prior to apietion of cause death? | |
| ete he | Š | | | | | | | 1 🗆 | Yes 20 No | 1 🗆 | Yes 2□ No | |
| this certificete | Be | 25. Was case referred to medical | | | | | 26. Plece of D | eath (Check only | one) | 1- | | |
| director director | 2 | examiner? 1¥ZYes 2□ No | Hospital: 1 ☐ Inpatie | nt 25ER | Outpetient | 3□ DOA | Other: 4 Nursing | Home 5 ☐ Resi | dence 6 □Ott | ner (Specify | () | |
| er th | | 27, Manner of Death | 28a. Date of inju (Month, De) | | b. Time of | 28c. | Injury at Work? | | how injury occur | | | |
| or death. actor: After by the funer | 읉 | 1 Alaturai 5 Pending 2 Accident investigation | | / rear/ | injury | М | 1 Yes 2 No | | | | | |
| within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, | Certification: | 3 Suicide 6 Could not be determined | 28e. Place of injubuliding, etc | ury - At home. | , farm, stre | et, factory, of | ice | 28f. Location (City or To | Street end Numi wn, Stete) | ber or Rure | / Route Number, | |
| within 24 hours | edicai | | nyaician: To the best of miner: On the basis of and manner sta | examination | | | | | | | | |
| within 2 To the | - | 29b. Signature and title of certifies | and married sta | 111 | - | / 29c. Lie | ense number | | 29d. Dete signe | ed (Month. I | Day, Year) | |
| 8 ≒ 8 | | The state of the s | (11 | Me | 11 | 1 N | OTOG | 06 | A.10 | 7 | 11 97 | |
| | | flece | ext | ry | - | | TUT | 7 1 | 100 | . 1 | 7 17 | |
| 1 | | 30. Name and address of person who | completed cause of d | eath (item 23 | a) (Type, P | rint) | D. Z | | -1- | 11/12 | 20817 | |
| | | TRANCIS (M) | 79/B 10. | 215/2 | ERN | 1000 | & ND P | EIHE | ON 1 | MO | 20517 | |
| Stat | e | 31. Date filed (Month At 1992) | 1997 32. Regisfra | s Signature | ma_ 10 | -J. 00 | | | | | • | |

DHMH 16 Rev 6/95



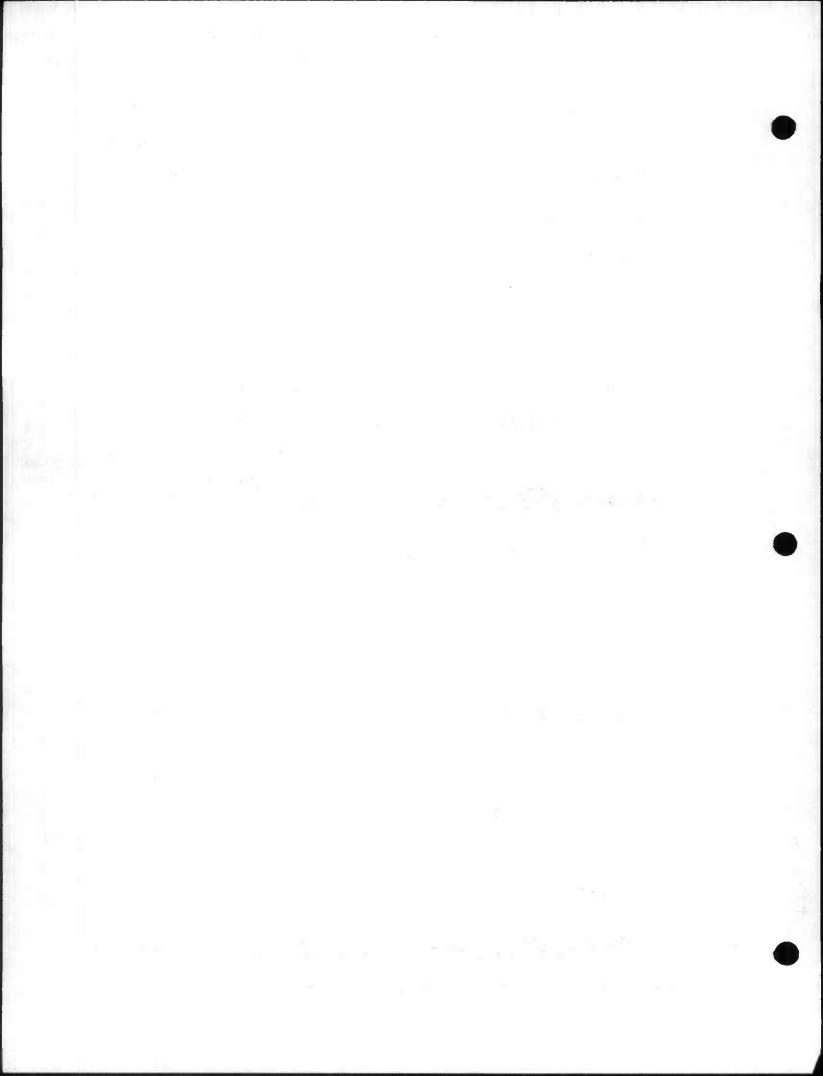
State of Maryland / Department of Health and Mental Hygiene 97 Certificate of Death 1. Decedent's Nema (First, Middle, Lest) 2. Date of Deeth 3. Time of Death 1997 Year August 23, **Physician** Francis John Piper /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Undar 24 Hrs. 8. Dete of Birth
Hours Min. Month, Dey, Year If Undar 1 Yaar 5. Sociei Security Number 7. Age (In yrs. lest birthdey) Birthplece (Steta or Foreign Country) 6. Sex **Funeral** Months Days 1 XM 2 ☐ F 69 Yrs. 314-24-1784 **Director** Feb. 5, 1928 Indiana Usual Residence of Decadant with the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f shot treumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Potomac 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20854 permit. Pages 1 and 2 should be filed within 72 hours efter death to Department of Haalih and Mantal Hygiena.

Important: if itam 27 is merked other than "naturelt, or items 28s any Injury or other treumetic event. the Martine 1. 11132 Hunt Club Drive United States Funeral 12. Wes Decedant Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Rece - American Indien, Bleck, White, atc. 1 XYas 2 No 1946− If Yes, Give Yaar or Dates: 1949 1 ☐ Nevar Marriad 2 X Married Baltimore, Maryland 21215-0020 Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Decedent's Usual Occupation
 (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Systems Analyst Computer Software 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meidan Surname) Francis J. Piper, Sr. Jewell Walenga 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) Martha W. Piper / Wife 11132 Hunt Club Drive, Potomac, Maryland 20854 20b. Piece of Disposition (Name of cametary, crematory or other piece) Aug. 28,1997 20e. Method of Disposition 20c. Location - City or Town, Steta 1 Buriel 2 Cremetion 3 Removel from Steta 4 ☐ Donetion 5 ☐ Other (Specify) Gate of Heaven Cemetery Silver Spring, Maryland 21. Signature of Funeral Sarvice Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 W. Montgomery Avenue, M00348Rockville, Maryland 20850-2805 Kulla 23a. Part1. Enter the disease, or complications that caused the daeth. Do not antar the mode of dying, such as cardiac or respiretory arrast, shock, or haart failure. List only one causa on aech line. Approximate erval Batween Onset and Death Physician /Medical Immediete Ceuse (Final diseese or condition resulting In deeth) Cardiovascular Dis ease & years **Examiner** Dua to (or es e consequence of) Examiner physician and the burial-transit Saquentielly list conditions, if eny, leeding to immediate cause. Entar Underlying Cause (Disease or Injury that Initiated avants resulting in death) Lest Due to (or es e consequance of): 2) 2050 M. Box 68760, Physician/Medical Dua to (or es e consequenca of): signed by the attanding d be detached for use as Part II. Other significent conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings aveileble prior to completion of causa of daeth? 24e. Wes en autopsy performed? Completed peen has 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical axeminer? 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Mnpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Data of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Dascribe how Injury occurred 1 Naturel 5 Panding death. 1 ☐ Yes 2 ☐ No Investigation or Attend after death Director: A 2 Accident 6 Could not be 3 Sulcide 28f. Location (Street end Number or Rural Routa Number, City or Town, Steta) 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 Homicida To the Hospital of within 24 hours a vithin 24 hours a rothe Funeral D completaly filled it 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, data end pleca, and due to the causa(s) end manner as steted. 29a. Certifier Medical 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, deta and place, and due to the ceuse(s) end menner stated. 29b. Signature and title of certifiar 29c. License number 29d. Date signed (Month, Day, Year) 20 30. Name end eddress of person who completed cause of daeth (Item 23e) (Type, Print)

6316 Democracy Blvd., Bethesda, Maryland 20817

32. Registrar's Signatura
Juna Davidson Randell

State Registrar Michael Emmer, M.D.,



Months

10f. Zip Code

Westminster

10c. City, Town or Location

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Days

| /Medicai Examiner |
|----------------------|
|----------------------|

1. Decedent's Name (First, Middle, Last) Warren Lee Ridings 2. Date of Death Month Ausust

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

4a. Facility Neme (If not institution, give street and number)

10b. County

4b. City, Town, or Location of Death

22,1997 11:05am 4c. County of Death

Virginia

5. Sociel Security Number **Funeral** 218-03-0763

MD

Carroll Lutheran Village Health Care 7. Age (In yrs. last birthday) 1 💢 M 2 🗆 F 78 Yrs.

Westminster If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3/16/1919

Carroll 9. Birthplace (State or Foreign Country)

Director the Marylend

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed w
Department of Health and Mental Hygien
Important: If Item 21 is marked other the
eny injury or other treumants

Physician /Medical

Examiner

physician end the buriel-transit

use ŏ

signed by t

peeu

page 2

director

After this funeral

Director: /

within 24 hours aft To the Funeral Dis completaly filled in

daath.

certificate

Box 68760

P.O.

Records,

Division of Vital Hospital or Attending Physicien: Examiner

Physician/Medical

Be Completed by

Certification: To

Medicai

Usual Residence of Decedent 10a State tem 27 is marked other than "naturel", or items 23s or 28s-1 show other treumstic event, the Medical Examinal must be notified as Director Funeral filed within 72 hours after of Hygiena. þ Completed

Be

347 Old New Windsor Pike

12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: W/W/77

College (1-4or 5+)

21158 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.)

10g. Citizen of What Country? United States

14. Race - American Indian, Black, White, etc.

1 Never Married 2 Married

3 Widowed 4 Divorced

Carroll

WWII 15. Decedent's Education (Specify only highest grade completed)

1 ☐ Yes 2 No Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

White 16b. Kind of Business/Industry

Elementary/Secondary (0-12)

Crane Mechanic

Steel

Specify:

17. Fether's Neme (First, Middle, Last) Harry Ridings

Catherine Baker

19a. Informant's Name/Relationship (Type, Print) Betty Ridings, wife

347 Old New Windsor Pike, Westminster, MD

20c. Location - City or Town, State

20a. Method of Disposition

1 Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) 8/26/97 Louden Park Cemetery

Baltimore, MD

21. Signature of Funeral Service Licenses

22. Name and Address of Facility

Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, MD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18. Mother's Neme (First, Middle, Maiden Sumame)

Kathurse Pritts - Suestier 412 Washington Rd.,
23e. Part1. Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line:

Approximate Interval Between Onset and Death

immediate Cause (Final disease or condition resulting in death)

Renal

Failure

6 Months

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Last

Due to (or es e consequence of):

Due to (or as a consequence of):

Due to (or es e consequence of):

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Hypertension

Refractory Congestive Heart Failure

24b. Were autopsy findings available prior to completion of ceuse of deeth? 24a. Was an autopsy performed?

Chronic Obstructive Pulmonary Disease

1 ☐ Yes 2 ☐ No

25. Wes cese referred to medical Hospital:

26. Place of Death (Check only one)

Other: Nursing Home 5 Residence 8 Other (Specify)

1□ Yes 2 No 27. Menner of Death Natural 2 Accident

3 Suicide

4 Homicide

5 Pending Investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

niner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end member stated.

28d. Describe how injury occurred

29a. Certifier (Check only one)

28e. Place of tnjury - At home, farm, street, factory, office 12 Certifying Pi 2 Medical Exa of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) and manner as stated. Physician: To the best

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature a

29c. License number

29d. Date signed (Month, Day, Year)

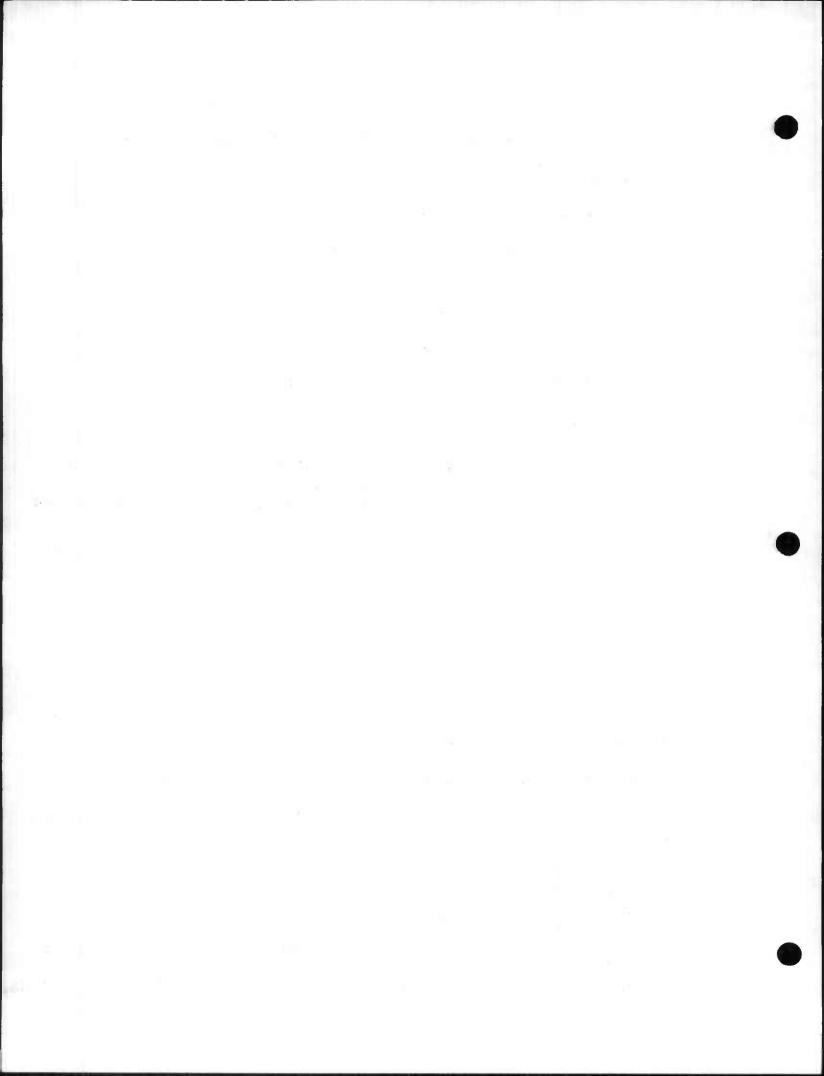
1737949

August 25th 1997

30. Neme end address of person (Ite 28a) (Type, Print)

Alexander Baylaschen gle 1425 Wherey Rd. Suite #208, Etderdry (mw)

State Registrar



| 3 / - | 4654-(| 05 | Please | Type or Pri | nt in Bla | ack Inde | lible Ink | . Assure A | II Copies | Are Leg | ible. | |
|------------|--|------------------|---|--|-------------------------------------|------------------------------------|---------------------|--|------------------|-----------------------------|-----------------------|---|
| V | ILLIAN | 1 | | State of Ma | aryland | / Departr | nent of I | Health and | Mental Hy | giene 9 | 1 2 | 7225 |
| | | | Items:23a part I,27, | | | Certif | icate of | Death | | Reg. No. | | |
| - 1 | Physic | an | 1. Decedent's Name (First, Middle, L | | | | | | 2. Date of De | eath Day | Year | 3. Tima of Death |
| | /Medi | | William | Henry Re | edman | , Sr. | | | AUGUST | 18 1 | | 7:45P.M. |
| | Exami | ner | 4a. Facility Name (If not institution, g | G SAN GARAGE | | | | 4b. City, Town, or I | Location of Deat | h 4c. Count | y of Death | |
| | | | 4805 DEER PARK 5. Social Security Number 6. | | e (In yrs. las | t highelass) H | Under 1 Year | RANDALI If Under 24 Hrs. | | | IMORE | |
| | Funeral Director | | 216-36-1694 | Sex 7. Ag 1 ☑ M 2 ☐ F | 58 | | onths Days | | (Month, De | 9y, Year) 5, 1938 | Country Mary. | ce (State or Foreign |
| | p | | Usual Residence of Decedent | | | | | | rag. Z. | 3, 1330 | raity. | Luiu |
| | filed within 72 hours efter death with the Maryland Hygiene. ther than "natural", or Items 23s or 28s-f show the the Medical Examinet must be notified at | <u>_</u> | 10a. State 10b. County | | 10c. City, T | own or Location | on | | | | 100 | d. Inside City Limits |
| | Ne M | Director | MD Balti | nore | | | ngs Mi | lls | | | | 1 ☐ Yes 2 【XNO |
| | 23a or 2 | Dir | 10e. Sireel and Number | _ | | 1 | Of. Zip Code | | | 10g. Citizen of | | n |
| | eath | Funeral | 4805 Deer Park 1 | Road 12. Was Oecedeni | Ever in U.S. | 13 Was | | 117 | pacifu Vas or Nr | | S.A. ce - American | Indian |
| 0 | frer dea | Fun | 1 Never Married 2 Married | Armed Forces? | | | | Hispanic Origin? (S ean, Mexican, Puert | o Rican, etc.) | Bla | ick, White, ele | |
| 020 | sl', or | by | 3 ☐ Widowed 4 ☐ Divorced | If Yas, Give Year or Dates: | | 10 | res 2⊠No | Specify: | | Specia | y: Whi | .te |
| 21215-0020 | 72 hours "natural", | eted | 15. Decedent's E (Specify only highast g | ducation rade completed) | 1 | 6a. Decedant's | s Usual Occu | pation during most of world) | rkina | 16b. Kind of E | Business/Indu | stry |
| 121 | s within 72 h liene. r than "netu | mpi | Elementary/Secondary (0-12) | College (1-4or 5 | i+) | | OT use retire | | | Mil | 1 | |
| 9 | Hygie ther i | Be Completed | 17. Father's Name (First, Middle, Las | | | | | 18. Mother's Nan | ne (First Middle | | | |
| lan | Baltimore, Maryland 212. permit. Pages 1 end 2 should be filed within Depertment of Health end Mental Hygiene. Important: If flem 27 is marked other than any injury or other traumatic event, the Magnes. | To Be | Roland E. Red | | | | | | ellena | | | |
| ary | | ⊢ | 19a. Informant's Name/Raiationship | (Type, Print) | | 19b. Mailing Ad | ddress (Street | t and Number or Ru | ıral Route Numb | er, City or Town | , Steta, Zip C | ode) |
| Σ | | | Mr. William H. | Redman, Jr | . (Son |) 6427 | Lincol | n Court | Glen Bur | mie, M | 21061 | |
| ore | | | 20a. Method of Disposition 1 | Removal from State | cem | e of Disposition etery, cremeto | y or other pla | ce) | Date | 20c. Location | | |
| E | | | 4 □ Donation 5 □ Other (Spec | | Spr | ingfiel | | | 8/21/97 | | • | MD |
| Sali | | | 21. Signature of Funeral Service Lice | . / | / | 22. Na HAIC | me and Addre | ess of Facility IERAL HOMI | E & CHAI | PEL (Box | (195) | |
| | 20290 | | brean of | . Waigl | - | Syke | esville | , MD 2178 | 84 (410) | -795-14 | | |
| | | | 23a. Part1. Enfer the disease, or con shock, or haart failura. List only | nplications that caused one cause on aach lie | lihe death. I ne. | Do not enter the | e mode of dyl | ng, such as cardiad | or respiratory a | rrest, | ir | Approximate ntarval Batween Onset and Death |
| | Physician /Medicai | | Immediate Causa (Final | ** *** | 04 4445 | | | | | | | miset and Death |
| | Examiner | | disease or condition resulting in death) | d. | | AMITRIPTY a consequence | | | 1 | | | |
| ч | n = | ner | | | Dua to (or as | a consequent | J o 01). | | | | 1 | |
| | the death certificete be executed y the attending physician end tched for use as the burial-transit | Examiner | Sequantially list conditions, | b. ————— | Due to (or as | a consequent | a of): | | | | | |
| 60, | be execian cian e | - 1 | if any, leading to immediata cause. Enter Underlying Causa (Disaase or Injury | 6 | | | | | | | | |
| 68760, | rificete be ng physici as the bu | dic | that initiated avents resulting in death) Lasf | | c. Due to (or as a consequence of): | | | | | | | |
| Box (| nding use a | J/Me | | d | | | | | | | | |
| m. | death cer attendir d for use | iciai | Part II. Other significant conditions | contributing to death by | at not reculting | on to the under | uina couca ai | ron in David | 22h Did | tebassa usa sa | indulbrate do d | ha anusa ad daath' |
| P.0 | | Physician/Medica | Tarrii. Other significant conditions | Softing to death bi | at not resultin | ig in the under | ying cause gr | ven in Part I. | | Yes 2 No | 3 □ Probe | he cause of death' bly 4 Unknow |
| | de de | by F | | | | | | | | | | 1 |
| Records, | v requires been sign should be | | | | | | | | 24a. Was | an autopsy ormed? | availe | autopsy findings able prior to |
| ec | 285 | Completed | | | | | _ | | | | of de | pletion of cause ath? |
| | E se | Cou | | | | | | | 100 | Yes 2□No | 1/2 | Yes 2□ No |
| V Ita | Physician: The rthis certificate rail director, pag | Be | 25. Was casa referred to madical examiner? | Hospital: | | | Ott | 26. Place of Dea | | | | |
| of Vital | Phys this ral di | 2 | 1)X Yas 2 No 27. Manner of Death | 1 Inpatie | | Outpatient 3 b. Time of p | □ DOA | har: 4 Nursing H | ome 5 Resi | idenca 6 DOti | ner (Specify) | WOODS |
| on | Attending I r death. octor: After by the funer | tlor | 1 □ Natural 5 ▼ Panding investigation | (Month, Day | Year) | Injury | Wo | | | | | th alcohol |
| Division | Attendi or death octor: A by the f | Iffica | 3 Sulcide 6 □ Could noi I | 09 20/3/ | | 40 | | | | | | Poute Number, |
| Ö | s effe | Certification: | 4 Homicide | in the woo | | | | | Randallst | wn, Stete) 480 Own, Mary | o Deer F land | 'ark Koad, |
| | To the Hospital or Attent within 24 hours effer deat To the Funeral Director: completely filled in by the | edical (| 29a. Cartifiar 1 Certifying P | nyelcian: To the bast of minar: On the basis of | of my knowle | dge, death occ | urred at the ti | ma, data and place | , and due to the | cause(s) and m | anner as stat | ed. |
| | the hin 24 the F | Medi | one) | and manner sta | itad. | C. IGO III IVOSIII | | | noo ar me mile, | | | |
| | 0 1 × 0 | ~ | 29b. Signature and title of certifier | 8029 03 | ~ | | 29c. Licens | se number | | 29d. Dafe signe | ed (Month, De | ly, Year) |

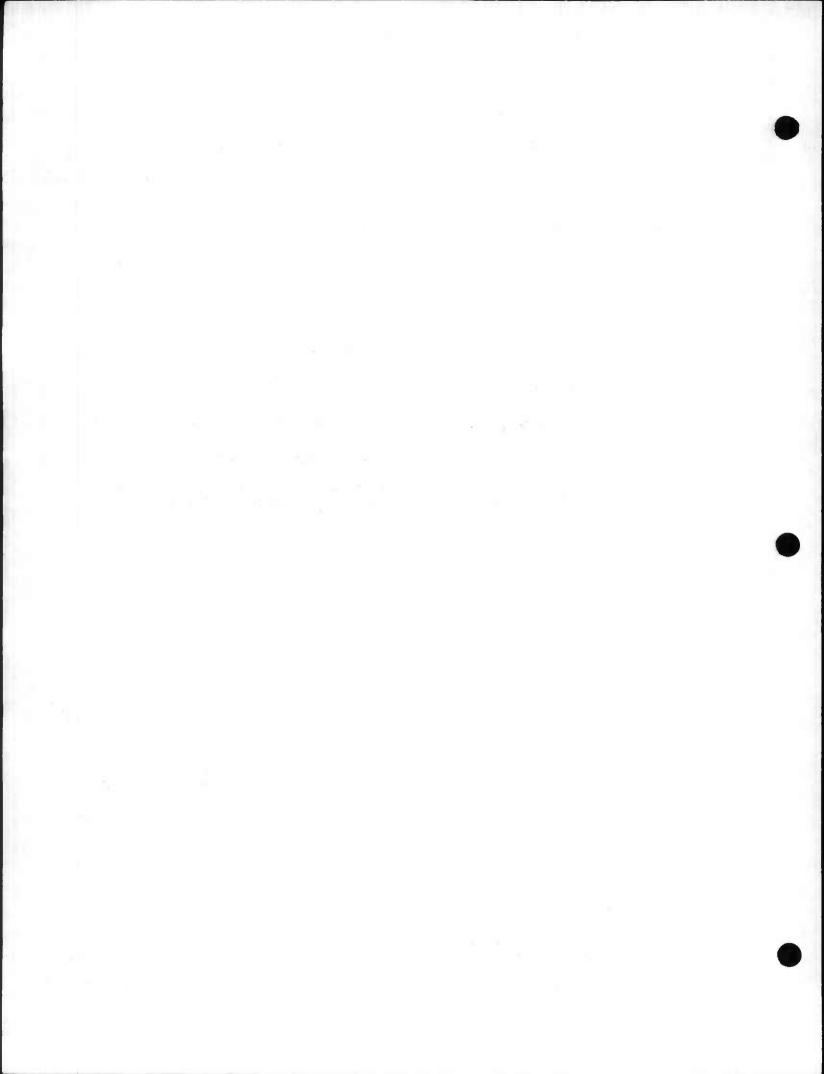
State Registrar

31. Date filed (Month, Day, Year)
AUG 2 5 1997

111 Penn Street, Baltimore, Maryland 21201

AUGUST 19,1997

O.C.M.E.



State of Maryland / Department of Health and Mental Hygiene Amend #10f, #10g, 12, 9/2/97, BMW, Montg. Co Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day John Samuel Raver 1997 August 26, 5:10PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Potomac Valley Nursing Home Rockville Montgomery If Under 1 Months Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** MXM 2□ F Yrs 69 Director 579-36-2236 Dec. 28, 1927 Washington, DC Usual Residence of Decedent the Manyland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 end 2 should be filed within 72 hours eftar death with the Marylar neat of Health and Mental Hygione. In: If fear 27 is marked other than "natural; or items 23a or 28a-f show int: If fear 27 is marked other than "natural; or other traumatic event, its Massas Exames must be not Director 1 Yes 2 No Maryland Frederick Frederick 10e, Street and Number 10f. Zlp Code 10g. Citizen of What Country? 9321 20701 9321 21701-9312 2429 Bear Den Road United State States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ②Yes 2 □ No If Yes, Give Year or Dates: 1946–1949 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Executive Programming Manager IBM 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Samuel Blow Raver Ernestine Rupp 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois J. A. Raver 2429 Bear Den Road, Frederick, Maryland 21701-9321 20b. Place of Disposition (Name of cemetery, crematory or other place) August 28,1997 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal Irom State permit. Page Depertment of Important: If any injury or Montgomery Crematory, Inc Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Lice 22. Name and Address of Facility Robert A. Pumphrey Funeral Home eme 300 W. Montgomery Ave., Rockville, Maryland 20850 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between **Physician** /Medical Immediate Cause (Final Arrhythmia disease or conditior resulting in death) few minutes Examine Due to (or as e consequence of): Physician/Medical Examiner ician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. physi the b Due to (or as a consequence of) 50 P.O. Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 2 1 □ Yes 2 No 3 □ Probably 4 □ Unknown Endstage Parkinson's Disease been signed the should be determined to the should be determined to the should be determined to the should be should be determined to the should b Records, þ 24b. Were autopsy lindings available prior to completion of ceuse of death? Completed 24a. Was en eutopsy performed? Sepsis page 2: certificate 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: funeral director. Be 25. Was cese referred to medical examiner? 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Affer 1 Natural 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, Iarm, street, lactory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es steted. cal 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certilier 29c. License number 29d. Dete signed (Month, Day, Year) rallam D42518 August 27, 1997 0+ 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Gul Chablani, M.D. 1111 Rockville Pike, #316, Rockville, Maryland 20852 31. Date liled (Month, DAUG'2 9 199 32. Registrar's Signature State

Julia Davidson

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last). 2. Date of Death **Physician** August 26, 1997 Agnes D. Ridgeway 5:20P.M. /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street end number) 4c. County of Death **Examiner** Hillhaven Nursing Home Adelphi Prince George's 5. Social Security Number If Under 1 Year if Under 24 Hrs. 8. Date of Birth (Month Dev Year) April 5,1912 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign **Funerai** Days Hours 1 M 200 214-14-6471 85 Yrs. Pennsylvania Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes ¾XNo Maryland Prince George's **Beltsville** Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20705 4910 Harford Avenue United States permit. Pages 1 and 2 should be filled within 72 hours efter death v Deperment of Health and Mental Hygiene. Important: if flem 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examinar must endite. Funeral 14. Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2XXVio White by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be unknown unknown 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Fred T. Ridgeway (husband) same as #10 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery 9/2/1997 Cheltenham, Maryland 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Part1. Enter the disease, of shock, or heert failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onsel end Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Examiner physician and the burial-transit Sequentially ilst conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 by Physician/Medical Due to (or as a consequence of) Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown onic Shotruchupulmonary disense 24b. Were autopsy findings available prior to completion of cause of death? butus Mulitus Completed 24a. Was an autopsy 1 Yes 20XNo 1 Tyes 2 Nin To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certification plately filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Placa of Death (Check only one) Hospital: Other: XX Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

4 - Homicide

29a. Certifier

29b. Signalufe

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Pamela Mulshine, M.D. 11251 Lockwood Drive Silver Spring, Maryland 20901 31. Date filed (Month Day 28 1997

hilia Davidson-Randelle

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Yeer) August 27, 1997

State of Maryland / Department of Health and Mental Hygiene 97 27228

| _ | | | | | | | | Cei | rtificat | e of | f Death | 1 | | Reg. I | No. | | | |
|------------|--|------------------|---|-----------------------|--|--------------------------|------------------------------|-------------------|-------------------------------------|---------------|------------------------------|------------------------|-------------------------------------|---|----------------------------|--------------------------------|---|--|
| | Physic | an | 1. Decedent's Neme (First, I | | | | | | | | | | 2. Dete of D | | Dev | Yeer | 3. Time of Deeth | |
| | Physic /Medi | | RANDOLPH W. | RE | ED, JR. | | | | | | | | aug | | | 1997 | 0115 | |
| | Exami | | 4e. Facility Neme (If not insti | _ | | | | | | | 4b. City, T | own, or L | ocation of Dee | th | 4c. County | of Death | | |
| | | | PENINSULA R | | | ICAL | CENTE | R | | | | LISI | BURY | | W | ICOM] | CO | |
| 1 | Funeral Director | | 5. Sociel Sacurity Number 579–12–4826 | | Sex 1⊠M 2□F | 7. Age 76 | (In yrs. lest b | irthday) Yrs. | If Under Months | 1 Yee Deys | | Min, | 8. Dete of B (Month, D AUGUST | av. Ye | 1920 | 9. Birthp Court WASI | elece (Stete or Foreign etry) HINGTON, DC | |
| | pue * |] | Usuel Residence of Deceder 10a. State 10b. Co | | | | 10c. City, Toy | wn or Lo | cation | | | | | | | 1 | 0d. Inside City Limits | |
| | Sa-f sho | octor | MD MON | TGOM | IERY | | POTOMA | | oution | | | | | | | | 1Ã Yes 2 No | |
| | th with the 23a or 2 | Funeral Director | 10e. Street end Number 11641 GLEN RO | AD | | | | | 10f. Zip | | | | | 10g. 0 | A. | Vhet Cour | ntry? | |
| 020 | s i and 2 should be filed within 72 hours after death with the Maryland I Health end Mantal Hygiene. If health end Mantal Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, if a Medical Examinar must be notified at | by | 11. Maritel Stetus 1 □ Never Married 2 ☑ 3 □ Widowed 4 □ Divo | | 12. Was Dec Armed F 1 Ayes If Yas, G Yeer or I | orces? 2 □ No ive | | | Wes Deced f Yes, sped 1 ☐ Yes | | | | io Rican, etc.) | | | e - Americ k, White, WHI | | |
| 5-0 | 72 ho | ed | 15. Dec | edent's E | ducation rade completed |) | 168 | . Dece | dent's Usua | el Occu | upetion e during mo | st of worl | kina | 16b. | Kind of Bu | isiness/Ind | dustry | |
| 21215-0020 | be filed within tal Hygiene. d other than "event, tre Mar | Completed | Elementery/Secondery (0- | | College (| | (4 | life. I | DO NOT u | se retin | NTRAC' | | (III) | EL | ECTRI | CIAN | | |
| Maryland | Suld be filed with Mantal Hygiene. Briked other than atic event, tree | To Be C | 17. Fether's Neme (First, Mic RANDOLPH W. R | | • | | | | | | 18. Moth | | ne <i>(First, Middl</i> LB | e, Meid | <i>en Sum</i> em | e) | | |
| ary | should lend Man | - | 19e. Informent's Neme/Rala | ionship | (Type, Pnint) | · | 19 | b. Mellir | ng Address | (Stree | et and Numb | er or Ru | ral Route Num | ber, Cit | y or Town, | vn, State, Zip Code) | | |
| | 1 and 2 Health e | 1 | LAURANA REED | | WIFE | | 1. | 1641 | GLEN | RO | DAD, P | OTOM | IAC, MD | 208 | 354 | | | |
| Baltimore, | | | 20e. Mathod of Disposition 1 M Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) WILDWOOD BAPTIST CHURCH 8/30/97 BETH | | | | | | | | | | | on - City or Town, State ESDA, MARYLAND | | | | |
| Balti | permit. Page Department of Important: If any Injury or once. | | 21. Signature of Funarel Ser | | | | | J(| Name en | d Addr | ress of Fecil WLER 'S | ity S SO | NS, INC | . 5 | 130 W | I AVI | ENUE, N.W. | |
| | | | 23e Parti Entelith | Or con | nolications that | caused t | the death. Do | W | ASHIN | GTO | N. D. | C. 20 | 0016 | | | | | |
| | Physician /Medical | | 23e. Par(1. Enter/hhadren shock, or heart and a Immediate Ceuse (Final disease or condition | List only | one ceuse on | eech line | Ox l | /. | | | by Th | | | | | \$ \$ 1 | Approximate interval Between Onset and Death | |
| | Examiner | | resulting in deeth) | | ө | | Due to (or es e | consec | juence of): | CYY | My/N | rua | _ | - | | | Gins. | |
| - | D # | iner | | | h. | , | Posts | | Hier | da | what | 12 | ntais | 1 | | - | 2 days | |
| | certificeta be executed ding physician end ise as the burial-transit | Examiner | Sequentially list conditions, | | 0. | D | ua to (or es e | conseq | yence of): | 1 | 1 | 0.4 | / | | | 1 | 9 | |
| 60, | cian burial | | Sequentially list conditions, if eny, laading to immediata causa. Enter Underlying Ceusa (Disaase or Injury that initiated evants | 1 | C | | Coron | 20 | 4 | 1/2 | Eu s | 1); | roal | | | | 10 ms. | |
| 68760, | physi the t | dle | that initiated evants resulting in death) Last | 1 | 0. | D | ue to (or es e | conseq | uence of): | / | | | | | | | | |
| 9 XC | certifice rding pl | Medical | | L | d | | | | (| | | | | | | | | |
| 8 | atten | cian | | | | | | | | | | | | | | 1 | | |
| , P.O. | thet the d ed by the deteched | by Physician | Part II. Other significant con | 4. E | contributing to d | Pras | not resulting | in the u | nderlying c | ause g | jiven in Pert | I. | | | co use cor 2□ No | atribute to 3 ☐ Prot | the cause of death? | |
| Records, | requir been s should | Completed b | Chanie | _/ | Cel | fa | lan S | ico | nday | 70 | ligh. | hos. | 24e. We per | s en eu iormed | topsy | eve | ere autopsy findings eileble prior to mpletion of cause death? | |
| | The ate h | | Chroni | <u> </u> | Atric | P | Fib | nle | afic | 2 | | | | | 2 12 No | 10 | Yes 2 No | |
| of Vital | | o Be | 25. Wes case referred to me exeminer? 1 ☐ Yes 2 ☑ No | dical | Hospital: | | | | | . 0 | thor | | th (Check only | | | | | |
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| Division | or Attending eftar daeth. Director: Aftei I in by tha fune | Certification: | 3 ☐ Suicida 6 ☐ Co | uld not t termined | e 28a. Place | e of Injur ling, atc. | ry - At homa, f (Specify) | arm, str | | | W 500 | | 28f. Location City or To | (Straat own, St | and Numb | er or Rura | I Route Number, | |
| | To the Hospital or Attendi within 24 hours eftar deeth. To the Funeral Director; A completely filled in by tha f | edical C | 29a. Certifiar 1 Cert | ifying Pi | hysician: To the miner: On the b end mer | asis of a | axamination er | a, daath | occurred vastigation, | et the t | time, deta er opinion, de | nd place, eth occur | and due to the | a causa , data e | (s) and me and place, a | nner es st | teted. o the causa(s) | |
| | o the | Me | 29b. Signeture end title of ce | rtifier | 0.00 11161 | | 1 | 1 | 290 | . Licen | nse number | | | 29d. I | Date signed | t (Month, | Day, Year) | |
| | ID D | |) Be | nel | 3 N | . , | Ka | u de | 0 | 0 | 7-20 | 305 | D | Schring | 8/2 | 6/ | br | |
| | | | 30. Name and address of per | son who | completed cau | sa of da | ath (Itam 23a) | (Туре, | Print) | Æ | יצעני | 310 | B. | | Sale | 2/ | KD=180 | |

State Registrar

579-12-4826 2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #8, 8/29/97, BMW, Montg. Co. per F.H. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Month 8-25-1997 MARY ROBERTS 3:45AM /Medical 4a. Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4525 SLEAFORD ROAD BETHESDA
If Under 24 Hrs.
Hours Min.
8. MONTGOMERY if Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthpiace (Stete or Foreign Country) **Funeral** Days 1 M 2 F Months Virs Director 054-121923 1-6-1918 Jan. 6, 1918 NEW LONDON, CT Usuai Residence of Deceden 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner name be notified at Director 1 No Yes 2 No MMD MONTGOMERY BETHESDA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 238 4525 SLEAFORD ROAD 20814 Funeral USA Items 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indien, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Merried No ¥Yes 2 No ¥Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 ò by Specify: WHITE 3. Widowed 4 □ Divorced "natural", Completed 15. Decadent's Education (Specify only highest grade completed) 16e. Decedent's Usuai Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hyglene. Eiementary/Secondary (0-12) College (1-4or 5+) 4YEARS HOUSEWIFE 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fill h end Mental H 'Is marked oth Be 2 DONALDSTEWART EFFIE BETHEL 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 20879 19e. Informant'a Name/Reletionship (Type, Print) permit. Peges 1 end 2 sh Department of Health end Important: If Item 27 Is in any Injury or other traun once. JUDY BETRICH 20615 HIGHLAND HALL DR. GAITHERSBURG, MD 20b. Piaca of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dete 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State Donation 5 ☐Other (Specify) GEORGETOWN MED SCH. 8-25-97 WASHINGTON, D.C. 21. Signeture of Funeral Service Licenses 22. Name end Address of Facility AUSTIN ROYSTER FUNERAL HOME 23 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 1. Street N.W., WASH, DC2001

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Approximately 1. Street N.W., WASH, DC2001

Approximately Approximate interval Between Onset end Deeth **Physician** aliablestoma multiforme brain tumor /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in death) Last Due to (or as a consequence of): physician s the burie Physician/Medical Due to (or es e consequença of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by I 1 Yee 2 No 3 Probably 4 Unknown þ Completed 24b. Were autopsy findinga available prior to completion of cause of death? 24a. Was an eutopsy performed? 2 12 No certificate 1 Yes 1 ☐ Yes 2 ☐ No 25. Waa case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Natural 5 Pending deeth. investigation 1 Yes 2 No 2 Accident 8 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Box 68760. Division of Vital Records, P.O. or Attending Physician: after deeth Director: To the Hospital of within 24 hours at To the Funeral D completely filled I

> 30. Name and eddress of person who completed cause of death (item 23a) (Type, Print) ROY FRIED, M.D. 10810 CONNECTICUT AVE., KENSINGTON, MD.20895 829199732. Registrate Signature 31. Date filed (Month, Da

12 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) end menner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) and manner stated.

29c. License number

D34590

29d. Date signed (Month, Dev. Year)

8-29-47

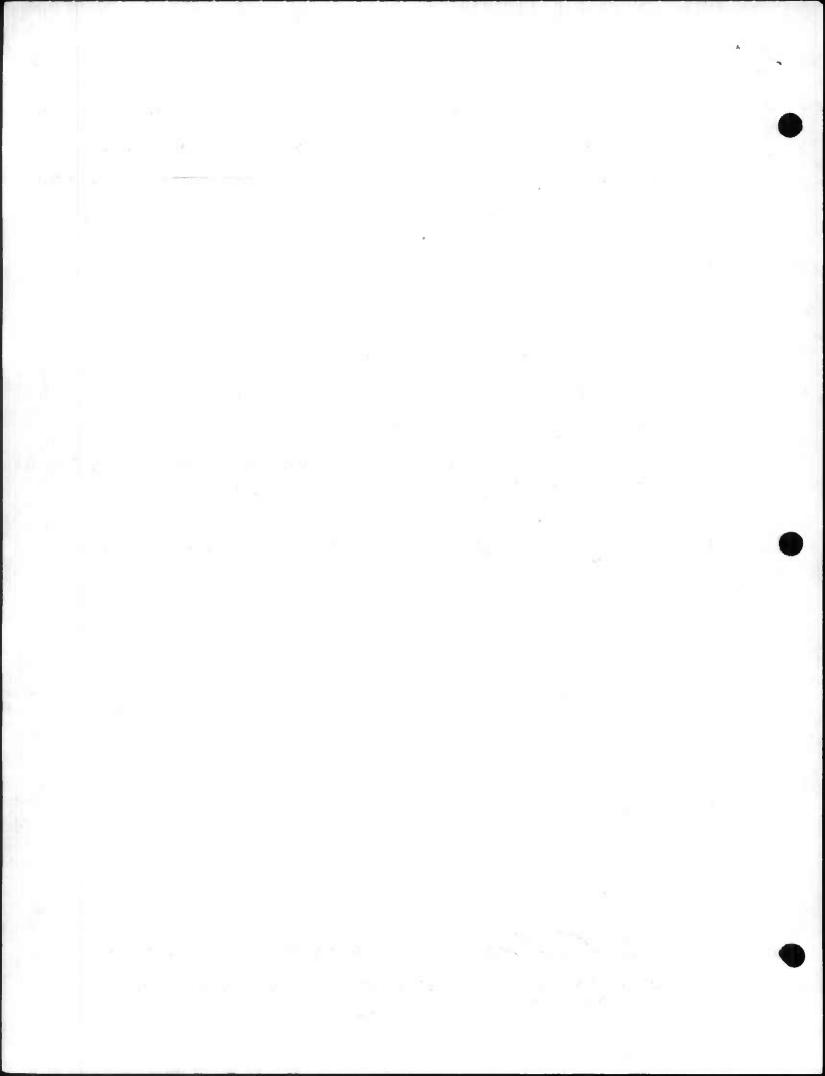
State Registrar

edicai

29a. Certifier (Check only one)

29b. Signature and title of cartifier

red

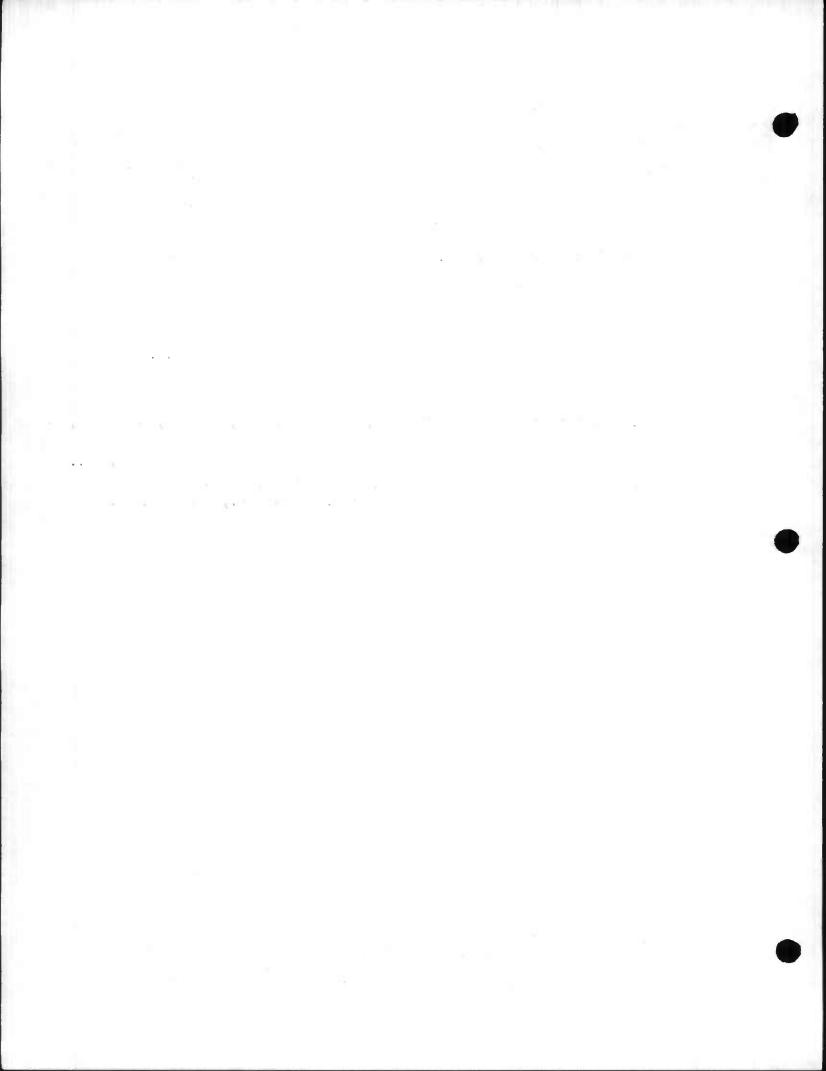


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 27230

| 4e. Facility Name (If not MALCOLM 5. Social Security Numb 180-42-6338 Usual Residenca of Dec 10e. Stete 10t Germany 10e. Street and Number Bld 403, S 11. Marifal Status 1 Never Married 3 Widowed 4 S (Specify of Elementary/Secondar 12 17. Fether's Neme (First Donald Ro 19e. Informent's Neme/ Jan B. Ros 20e. Method of Dispositi 12 Buriel 2 Cr. 4 Donetion 5 S | h Josej institution, giv GROW M er 6. S 3 edent b. County kyline 20 Married Divorced Decedent's Echy highest gre y (0-12) , Middle, Last) Se Reletionship (1) | HOUSING 12. Was Deceded Armed Forca 1 Days, Give Yeer or Deter | ENTER Aga (in yrs. 42 10c. Cit W Apt. nt Ever in U | Yr. Ty, Town of the Date of t | or Location Courg 10f. Z 13. Was Decilif Yes, sp 1 yes | der 1 Year s Deys | Hours Hispenic Originen, Mexican, I | PRIN Hrs. Min. | IGS B. Dete of Bin (Month, De June 1 | Dey 1 22, 19 h 4c. County PRINC th ay, Year) 1 10g. Citizen of USA 1 14. Rec | y of Deeth CE GEORG 9. Birthplece Country) Pennsy 10d. In 1 What Country? | (State or Foreign IVANÌA Inside City Limits □ Yes 2 No | |
|--|--|--|---|--|--|---|---|--|--|---|--|--|--|
| 4e. Facility Name (If not MALCOLM 5. Social Security Numb 180-42-6338 Usual Residenca of Dec 10e. Stete 10t Germany 10e. Street and Number Bld 403, S 11. Marifal Status 1 Never Married 3 Widowed 4 S (Specify of Elementary/Secondar 12 17. Fether's Neme (First Donald Ro 19e. Informent's Neme/ Jan B. Ros 20e. Method of Dispositi 12 Buriel 2 Cr. 4 Donetion 5 S | institution, giv GROW Mer 6. S 3 1 edent b. County kyline 20 Married Divorced Decedent's Ecoly highest grey (0-12) , Middle, Last) SE Reletionship (1 | EDICAL C. ex EDICAL 7. EWA 2 F 7. HOUSING; 12. Was Deceda Armed Force 1 12 Wes 2 [If Yes, Give Yeer or Detection de complated) Cottege (1-4c 3 | ENTER Aga (in yrs. 42 10c. Cit W Apt. nt Ever in U | Yr. Ty, Town of the Date of t | or Location Courg 10f. Z 13. Was Decilif Yes, sp 1 yes | der 1 Year s Deys | CAMP S If Under 24 Hours Hispenic Originen, Mexican, I | PRIN Hrs. Min. | AUGUST ation of Deet IGS 8. Dete of Bir (Month, De June 1 | PRINCE 10g. Citizen of USA | y of Deeth CE GEORG 9. Birthplece Country) Pennsy 10d. In What Country? ce- American Inck, White, etc. | EE'S (State or Foreign Ivania Ivania Inside City Limits I Yes 2 ANo | |
| MALCOLM 5. Social Security Numb 180-42-6338 Usual Residence of Dec 10e. Stete 10t Germany 10e. Street and Number Bld 403, S 11. Marifal Status 1 Never Married 3 Widowed 4 S 15. (Specify of Elementary/Secondar 12 17. Fether's Neme (First Donald Ro 19e. Informent's Neme/ Jan B. Ros 20e. Method of Dispositi 12 Buriel 2 Cr. 4 Donetion 5 S | GROW Meer 6. S 1 Bedent 5. County 6. SCOUNTY | Housing, 12. Was Decede Armed Force 1 (Days s 2) If Yes, Give Yeer or Dete | ENTER Aga (in yrs. 42 10c. Cit W Apt. nt Ever in U | Yr. Ty, Town of the Date of t | or Location Courg 10f. Z 13. Was Decilif Yes, sp 1 yes | der 1 Year s Deys | CAMP S If Under 24 Hours Hispenic Originen, Mexican, I | PRIN Hrs. Min. | ation of Deet IGS 8. Dete of Bir (Month, De | PRINCE 10g. Citizen of USA | y of Deeth CE GEORG 9. Birthplece Country) Pennsy 10d. It 1 What Country? ce- American Inck, White, etc. | EE'S (State or Foreign Ivania Ivania State City Limits State Yes 2 ANo | |
| 5. Social Security Numb 180-42-6338 Usual Residenca of Dec 10e. Stete 10t Germany 10e. Street and Number Bld 403, S 11. Marifal Status 1 Never Married 3 Widowed 4 15. (Specify or Elementary/Secondar 12 17. Fether's Neme (First Donald Ro 19e. Informent's Neme/ Jan B. Ros 20e. Method of Dispositi 12 Buriel 2 Cr. 4 Donetion 5 5 | er 6. S B edent County kyline 2[XMarried Divorced Decedent's Echly highest gre y (0-12) , Middle, Last) Se Reletionship (1) | Housing, 12. Was Deceded Armed Forca 1 Dives 2 If Yes, Give Yeer or Determined to complated) College (1-4c) | Aga (in yrs. 42 10c. Cit W Apt. Apt. No. S. | Yr. Ty, Town of the Date of t | or Location Courg 10f. Z 13. Was Decilif Yes, sp 1 yes | der 1 Yaar s Deys Zip Code | If Under 24 Hours | Min. | 8. Dete of Bir (Month, De June 1 | 10g. Citizen of USA 14. Rec | 9. Birthplece Country) Pennsy 10d. in 1 What Country? Dee - American Inck, White, etc. | (State or Foreign I Vania Inside City Limits ☐ Yes 2 ANo | |
| 5. Social Security Numb 180-42-6338 Usual Residenca of Dec 10e. Stete 10t Germany 10e. Street and Number Bld 403, S 11. Marifal Status 1 Never Married 3 Widowed 4 15. (Specify or Elementary/Secondar 12 17. Fether's Neme (First Donald Ro 19e. Informent's Neme/ Jan B. Ros 20e. Method of Dispositi 12 Buriel 2 Cr. 4 Donetion 5 5 | er 6. S B edent County kyline 2[XMarried Divorced Decedent's Echly highest gre y (0-12) , Middle, Last) Se Reletionship (1) | Housing, 12. Was Deceded Armed Forca 1 Dives 2 If Yes, Give Yeer or Determined to complated) College (1-4c) | Aga (in yrs. 42 10c. Cit W Apt. Apt. No. S. | Yr. Ty, Town of the Date of t | or Location Courg 10f. Z 13. Was Decilif Yes, sp 1 yes | der 1 Yaar s Deys Zip Code | If Under 24 Hours | Min. | 8. Dete of Bir (Month, De June 1 | 10g. Citizen of USA 14. Rec | 9. Birthplece Country) Pennsy 10d. in 1 What Country? Dee - American Inck, White, etc. | (State or Foreign I Vania Inside City Limits ☐ Yes 2 ANo | |
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| Usual Residence of Dec 10e. Stete 10t. Germany 10e. Street and Number Bld 403, S 11. Marifal Status 1 Never Married 3 Widowed 4 Secrety of Elementary/Secondar 12 17. Fether's Neme (First Donald Ro 19e. Informent's Neme/Jan B. Ros 20e. Method of Dispositi 12 Buriel 2 Cr. 4 Donetion 5 D | kyline 2[XMarried Divorced Decedent's Econly highest gre y (0-12) , Middle, Last) SE Reletionship (1 | 12. Was Deceda Armed Forca 1 [2] yes 2 [If Yes, Give Yeer or Detection de complated) Cottege (1-4c | Apt. Apt. ont Ever in U. s? | A-3 | 10f. Z 10f. Z 10f. Z 13. Was Dec If Yes, sp 1 Yes | cedent of Hoecify Cub | en, Mexican, I | n? (Spec | cify Yas or No | 10g. Citizen of USA | 10d. ii 1 What Country? ce - American Inck, White, etc. | nside City Limits ☐ Yes 2 1 No | |
| 10e. Stete 10t Germany 10e. Street and Number Bld 403, S 11. Marifal Status 1 Never Married 3 Widowed 4 Secretive 15. (Specify or Elementary/Secondar 12 17. Fether's Neme (First Donald Round 12) 19e. Informent's Neme/Lyan B. Ros 20e. Method of Disposition 12 Buriel 2 Cruel Conduction 5 C | kyline 2[XMarried Divorced Decedent's Econly highest grey (0-12) , Middle, Last) SE Reletionship (1 | 12. Was Deceda Armed Forca 1 [2] yes 2 [If Yes, Give Yeer or Detection de complated) Cottege (1-4c | Apt. Apt. Int Evar in U. S? No s: | A-3 | 10f. Z 10f. Z 10f. Z 13. Was Dec If Yes, sp 1 Yes | cedent of Hoecify Cub | en, Mexican, I | n? (Spec Puarto R | cify Yas or No cican, afc.) | USA 14. Rec Ble | What Country? ce - American Inck, White, etc. | ☐ Yes 2∰No | |
| 10e. Street and Number Bld 403, S 11. Marifal Status 1 Never Married 3 Widowed 4 Sepecify of Elementary/Secondar 12 17. Fether's Neme (First Donald Ro 19e. Informent's Neme/ Jan B. Ros 20e. Method of Dispositi 1 Buriel 2 Cr. 4 Donetion 5 Sepecify of Ros | 20X Married Divorced Decedent's Ecc hly highest gre y (0-12) , Middle, Last) SE Reletionship (1 | 12. Was Deceda Armed Forca 1 [2] yes 2 [If Yes, Give Yeer or Detection de complated) Cottege (1-4c | Apt. nt Evar in U s? No | A-3 | 13. Was Dec | cedent of Hoecify Cub | en, Mexican, I | n? (Spec Puarto R | cify Yas or No lican, afc.) | USA 14. Rec Ble | What Country? ce - American Inck, White, etc. | ☐ Yes 2∰No | |
| 10e. Street and Number Bld 403, S 11. Marifal Status 1 Never Married 3 Widowed 4 Sepecify of Elementary/Secondar 12 17. Fether's Neme (First Donald Ro 19e. Informent's Neme/ Jan B. Ros 20e. Method of Dispositi 1 Buriel 2 Cr. 4 Donetion 5 Sepecify of Ros | 20X Married Divorced Decedent's Ecc hly highest gre y (0-12) , Middle, Last) SE Reletionship (1 | 12. Was Deceda Armed Forca 1 [2] yes 2 [If Yes, Give Yeer or Detection de complated) Cottege (1-4c | Apt. nt Evar in U s? No | A-3 | 13. Was Dec | cedent of Hoecify Cub | en, Mexican, I | n? (Spec Puarto R | ify Yas or No lican, afc.) | USA 14. Rec Ble | ce - Amarican In ck, White, etc. | | |
| Bld 403, S 11. Marifal Status 1 Never Married 3 Widowed 4 Sepecify or Elementary/Secondar 12 17. Fether's Neme (First Donald Ro 19e. Informent's Neme/ Jan B. Ros 20e. Method of Dispositi 1 Buriel 2 Cr. 4 Donetion 5 September 1 | 20X Married Divorced Decedent's Ecc hly highest gre y (0-12) , Middle, Last) SE Reletionship (1 | 12. Was Deceda Armed Forca 1 [2] yes 2 [If Yes, Give Yeer or Detection de complated) Cottege (1-4c | nt Evar in U s? ⊡ No s: | ,S. | 13. Was Dec If Yes, sp 1 ☐ Yes | cedent of Hoecify Cub | en, Mexican, I | n? (Spec Puarto R | ify Yas or No ican, afc.) | USA 14. Rec Ble | ce - Amarican In ck, White, etc. | | |
| 11. Marifal Status 1 Never Married 3 Widowed 4 Sepecify of Elementary/Secondar 12 17. Fether's Neme (First Donald Ro 19e. Informent's Neme/ Jan B. Ros 20e. Method of Dispositi 1 Buriel 2 Cr. 4 Donetion 5 Sepecified | 20X Married Divorced Decedent's Ecc hly highest gre y (0-12) , Middle, Last) SE Reletionship (1 | 12. Was Deceda Armed Forca 1 [2] yes 2 [If Yes, Give Yeer or Detection de complated) Cottege (1-4c | nt Evar in U s? ⊡ No s: | ,S. | 13. Was Dec If Yes, sp 1 ☐ Yes | ecify Cub 2☐{No | en, Mexican, I | n? (Spec Puarto R | ify Yas or No lican, afc.) | 14. Rec | ck, White, etc. | | |
| 1 Never Married 3 Widowed 4 Specify or Elementary/Secondar 12 17. Fether's Neme (First Donald Ro 19e. Informent's Neme/ Jan B. Ros 20e. Method of Dispositi 1 Dention 5 Specific Specif | Divorced Decedent's Ecchy highest gre y (0-12) , Middle, Last) SC Reletionship (1) | Armed Forca 1 [3] es 2 [If Yes, Give Yeer or Deter fucation de complated) Cottege (1-4c | s? □ No s: | 16e D | If Yes, sp | ecify Cub 2☐{No | en, Mexican, I | n? (Spec Puarto R | ify Yas or No lican, afc.) | Ble | ck, White, etc. | | |
| 3 Widowed 4 Strong Stro | Divorced Decedent's Ecchy highest gre y (0-12) , Middle, Last) SC Reletionship (1) | 1 Des 2 If Yes, Give Yeer or Determined complated) Cottege (1-4c 3 | □ No s: | 16e. D | 1 ☐ Yes | 2 \ No | | Jano | iouri, ajo., | 111-00 | | te | |
| 15. (Specify of Elementary/Secondar 12 17. Fether's Neme (First Donald Ro 19e. Informent's Neme/Jan B. Ros 20e. Method of Disposition 12 Burlei 2 Cr. 4 Donetion 5 | Decedent's Econly highest grey (0-12) , Middle, Last) SE | Yeer or Determined of Cottege (1-4c) | | 16e. D | Decedent's Us | | Specify: | | | Specif | y: Whi | te | |
| (Specify of Specify of Elementary/Secondar 12) 17. Fether's Neme (First Donald Ro 19e. Informent's Neme/Jan B. Ros 20e. Method of Dispositi 1 2 Burlel 2 Cr. 4 Donation 5 D | nly highest gre y (0-12) , Middle, Last) SE Reletionship (1 | de complated) Cottege (1-4c | or 5+) | 16e. D | Decedent's Us | | | | Spe | | Specify: White | | |
| Elementary/Secondar 12 17. Fether's Neme (First Donald Ro 19e. Informent's Neme/ Jan B. Ros 20e. Method of Dispositi 112 Buriel 2 □ Cr. 4 □ Donetion 5 □ | y (0-12) , Middle, Last) SE Reletionship (1) | Cottege (1-4c | or 5+) | (C | GIVE KIND OF W | suel Occup | petion | | ing 16b. Kind | | (Ind of Business/Industry | | |
| 12 17. Fether's Neme (First Donald Ro 19e. Informent's Neme/ Jan B. Ros 20e. Method of Dispositi 112. Buriel 2 □ Cr. 4 □ Donetion 5 □ | , <i>Middle, Last)</i> SE Reletionship (1 | 3 | or 5+) | | me. DO NOT | vork dona use retire | during most o | f workin | 9 | | | | |
| Donald Ro 19e. Informent's Nement Jan B. Ros 20e. Method of Dispositi 1 Burlel 2 Cr. 4 Donetion 5 | SE Reletionship (1 | | | | | | | | | U.S. Army | | | |
| Jan B. Ros 20e. Method of Dispositi 1 Buriel 2 Cr. 4 Donetion 5 | Reletionship (| | | | | | 18. Mother's | Name | (First, Middle | Meiden Sumar | | | |
| Jan B. Ros 20e. Method of Dispositi 1 Buriel 2 Cr. 4 Donetion 5 | Reletionship (| | | | | | | | | | ne | | |
| Jan B. Ros 20e. Method of Dispositi 1 Buriel 2 Cr. 4 Donetion 5 | | nuis natur | | 4.00 | | 16 | | | th Dez | | ally man | | |
| 20e. Method of Dispositi 1 2 Buriel 2 Cr 4 Donetion 5 | e (Wife | | | | - | | | | | er, City or Town | | | |
| 1 Buriel 2 Cr. 4 Donetion 5 | | ∋) | | | | | ine Hou | ısin | ng, Apt A-3, Wuerzburg, Deta 20c. Location - City or Town, Sta | | | | |
| 4 Donetion 5 D | | Demonstra Cto | | Piece of D cemetery, | Disposition (No.), cremetory or | leme of r other pla | ce) | | Deta | 20c. Location | - City or Town, S | itata | |
| OI CONTRACTOR | | | | wnvi | ew Cem | eter | V | 8/2 | 28/97 | Rockle | dge, Pa | | |
| 21. Signature di Funera | Servica Licen | 800 | | | | | | | | 1001110 | age, Iu | , • | |
| 1 de X | 0 | . / | | | | | oss of Eacility On Fune | | | | | | |
| CITY | Ma | | | | 390 | 1 N. | Fairfa | ex D | r.,Arl | ington, | | | |
| 23a. Pert1. Enter the or shock, or heart this | sease, or comp une. List only | n cetions that caus the ceuse on each | ed the deet line. | h. Do not | ot enter the mo | ode of dylr | ng, such es ca | rdiec or | respiretory e | rrest, | Inte | roximete rvel Between | |
| | | | | | | | | | | | Ons | at and Deeth | |
| disease or condition | | e. SEPSIS | | | | | | | | | | | |
| resulting in death) | | Due to (or es e consequenca of): | | | | | | | | OD WAMINE | | | |
| | | PNETIMONT A | | | | | | | - ht | | | | |
| Cognentially list condition | | 0. | | | | | Kukus Br WEDIG | | | | | | |
| if eny, leading to immed | iete | 259 1 | Due to (or es e consequenca of): | | | | | . Rd | | | | | |
| Cause (Diseese or injury | | C | c. 25% TBSA BURNS | | | | | | TONTON AN | | | | |
| resulting in deeth) Lest | | | Due to (o | r as e cor | nsequence or | r): | CERT | 100 | No. | | | | |
| | | d | | | | | | | | | | | |
| | , | | | | | | | | | | | | |
| Part II. Other significant | conditions of | ontributing to death | but not resi | ulting in fr | the underlying | cause giv | ven in Pert I. | | 23b. Did | tobacco use co | ontribute to the | cause of desth? | |
| | | | | | | | | | 10 | Yes 2 No | 3 Probably | 4 Unknown | |
| | | | | | | | | | | | | | |
| | | | | | | | | | 24e. Wss | sn eutopsy | 24b. Were e | utopsy findings | |
| | | | | | | | | | pent | Jillieu i | comple | ion of cause | |
| | | | | | | | | | | · Vi | | | |
| | | - | | | | | | | 10 | Yes ZAJ No | 1 LI Yes | 2 2 No | |
| axaminer? | | Hoenitai: 37 | | | | 0 | | Deeth | (Check only | one) | | | |
| | | 1+1 Inpa | | | | DUA | 4 LI Nurs | - | | | 1.1 . 77 | | |
| | Pending | 28e. Dete of Ir (Month, L | ojury De <i>y Year)</i> | | ne of ury | 28c. Injur Wor | ry et rk? | | 3d. Describe | how injury occur | rred | | |
| 2 Accident | investigetion | AUG 1Z | . 1997 | 7 | М | 10 | Yas 2 No | | MVA | | | | |
| | Could not be detarmined | 28e. Piece of I | njury - At ho | ome, ferm | n, street, facto | ory, office | | 28 | Sf. Location (| Street end Numi | ber or Rural Rou | ita Number, | |
| 4 | | building, etc. (Specify) | | | | | | | | | | | |
| 29a. Certifier 1X | Certifying Phy | | | | | d et tha tir | ma, deta end i | | | | enner es steted | | |
| (Check only 2 | Medicat Exam | tner: On the basis | of exemine | tion end/o | or investigation | on, in my o | ppinion, deeth | occurred | et the time, | date end placa, | and due to the | cause(s) | |
| | of certifier | 21.0 1.10111101 | | | 20 | 9c. Licens | a number | | | 29d. Date signs | ed (Month. Day | Year) | |
| | | 0 | / | 1 | | | | | | | - Imendia paly | / | |
| - 1.0 | | (/ same | / | | | | | | | | | | |
| Kuch | and | - small | ee L | rug | lece) | MD 05 | 5529L | PA | | AUGUST | 22, 199 | 7 | |
| | Immediate Ceuse (Final disease or condition resulting in death) Sequentially list condition if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Part II. Other significant 25. Wes case referred to axaminer? 1 Yes 2 No 27. Menner of Death 1 Neturel 5 28. Accident 3 Suicide 6 4 Homicide 29a. Certifier (Check only one) | Immediete Ceuse (Finat disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediete cause. Enter Undertying Cause (Disease or injury their inflieted events resulting in deeth) Lest Part II. Other significant conditions or aximiner? 1 Yes 2 No 27. Menner of Deeth 1 Neturel 5 Pending investigation 3 Suicide 6 Could not be detarmined. 29a. Certifier 1 Certifying Phy (Check only 2 Medicat Exam | Immediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. 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Were as everlable of death in the underlying cause given in Pert I. 1 Yes 2 No 1 Yes 25 Wes case referred to medicat axaminer? 1 Yes 2 No 1 Yes 25 Mener of Death (Check only one) 27. Mener of Death investigation 28c. Date of Injury (Month, Dey Year) 28c. Date of Injury (Month, Dey Year) 28d. Date of Injury At home, ferm, street, factory, office City or Town, State) GRAMANY 29a. Cartifier 1 Cartifying Physician: To the best of my knowledge, death occurred at that ima, deta end place, and due to the cause(s) and menner as steted. Check only only 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as steted. Check only only 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as steted. Check only only 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as steted. Check only only 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as steted. | |

State Registrar



Please Type or Print in Biack indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 27231

| | | | | late of Mary | | | | Death | vicinairiy | Reg. No. | 1 4 | . 1231 | | | | |
|---------------------|---|---|--|--|---|--|--------------------------------------|---|--|--------------------------------|---|---|--|--|--|--|
| | Physic | | Decedant's Nama (First, Middle, Last) George Fra | nklin | Stevens | | | | 2. Data of Da Month Augus t | Day | Year 1997 | 3. Time of Death $10:15\text{AM}$ | | | | |
| Α. | /Medi Examii | | 4a. Facility Nama (If not Institution, give street | | 550.0110 | | - | 4b. City, Town, or L | | | | 10.1241 | | | | |
| 1 | | | 938 Creek Drive | | | | | Annapo | lis | Uni | ted S | tates | | | | |
| | Funeral Director | | 5. Social Security Number 6. Sex 1 M | | yrs. lest birthday Yrs. | Months | Days | If Under 24 Hrs. Hours Min. | 8. Data of Bir (Month, De Dec 8 | rth ay, Year) | 9. Birthp Coun | lace (Steta or Foreigr try) | | | | |
| - | and | | Usual Residence of Decedant 10a. Stata 10b. County | | c. City, Town or L | ocation | | | T DOC 0 | 1727 | | 0d. Inside City Limits | | | | |
| | a Mary | Director | MD Anne Arund | el | A | nnapo | lis | | | | | 1 🖾 Yes 2 🗆 No | | | | |
| | 94 th | S. | 10e. Street and Number | | | 10f. Zi | p Coda | | | 10g. Citizen of V | What Coun | try? | | | | |
| | th w | <u>8</u> | 938 Creek Drive | | | | | 21403 | | United | Stat | es | | | | |
| 120 | s within 72 hours after death with the Maryland ilone. Then "netural", or items 23a or 28a-f show the Medical Examinet must be notined at | by Funeral | 1 □ Naver Married 2000 Married | Vas Decedent Evar umed Forcas? X Yas 2 □ No i Yes, Giva 'ear or Datas: | in U,S. 13. | Was Dece if Yes, spe 1 Yas | | lispanic Origin? (Sa an, Maxican, Puerto Specify: | pecify Yas or No Rican, etc.) | Specify | Race - American Indian, Black, Whita, atc. | | | | | |
| Maryland 21215-0020 | in 72 n nat | Completed b | 15. Decedent'a Education (Specify only highast grada con | n | 16a. Dece (Giv. life. | edant's Usi e kind of w DO NOT i | iai Occup ork done ise retired | eation during most of world) | king | 16b. Kind of B | of Business/Industry | | | | | |
| 2 | | E O | 12 | Johneyo (1-40/04) | | Owner | /Ope: | rator | | Ha | rdwar | е | | | | |
| pu | be filed ttal Hygie d other avant, tt | Bec | 17. Father's Name (First, Middle, Last) | | · | | | 18. Mother's Nam | ne (First, Middle | , Meiden Suman | na) | | | | | |
| /lai | | To | Louis A.C. Steven | s | | | | Minni | e F. Ha | mbrock | | | | | | |
| lan | d 2 should th and Mer 7 Is marks traumatic | | 19a. Informant's Name/Relationship (Type, F | Print) | 19b. Mei | ing Addres | s (Street | end Number or Ru | ral Route Numb | er, City or Town, | Steta, Zip | Code) | | | | |
| | 5 2 4 7 | | Marjorie K. Steven | s (Wife) | 93 | 8 Cre | ek D | rive Ann | apolis, | Maryla | nd 21 | 403 | | | | |
| Baltimore, | I I I | | 20b. Placa of Disposition 10 Ramoval from State 10 Donation 5 Other (Specify) 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State that the cemetery of the place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State that the cemetery of Date cemetery or other place) 21. Sporture of Funeral Service Library | | | | | | | | | | | | | |
| III | Departmar Mportant: any Injury | 1 | 1 | | | | | | | | | | | | | |
| Ba | Departme Departme Importan any Injur | ' | terrald S. J | with | | 147 D | uke (| of Glouce | M. Tay ster St | lor Fun . Annap | eral olis, | Home, Inc MD 21401 | | | | |
| | Physician /Medical Examiner | er | 23a. Part1. Enlar the disease, or complication shock, or heart failura. List only one call immediate Cause (Final disease or condition resulting in death) | Wal | to (or a a conse | nt | W | la such as cardiac | or respiratory a | irrest, | | Approximate Interval Between Onset and Death | | | | |
| x 68760, | ertificate be executed ding physician and ta as the burial-transit | /Medical Examiner | b. — Sequentially list conditions, if any, leading to immadiete cause. Enter Undarlying Cause (Disease or injury that initiated events rasulting in death) Last | | to (or as a conse | | | | | | | | | | | |
| Вох | death cer e ettendir ed for usa | ian | | | | | | | | | | | | | | |
| P.O. | that tha ed by th detache | / Physician/M | Part II. Other significant conditions contribute | ting to death but not | causa giv | | Yes 2 No | | ribute to the cause of death 3 Probably 4 Unknow | | | | | | | |
| Records, | law requires as been sign 2 should be | Completed by | | | | | | | | en eutopsy ormed? | ava coi | ore autopsy findings allable prior to mplation of causa death? | | | | |
| | The ata h | Comp | | | | | | | 10 | Yes 20 No | | Yes 2□ No | | | | |
| Vital | ilcian: The cartificata rector, pag | Be | 25. Was case reterred to medical examiner? | ha li | | | 100 | 28. Place of Dee | th (Check only | one) | | | | | | |
| to | Physician: this cartific ral director, | 7 | 1 Yas No Hospit | 1 L Inpatient | 2 ☐ ER/Outpatie | | | 4 LI Nursing H | | idence 6 Oth | | 0 | | | | |
| | Attanding For death. | ation | 27. Manner of Death' 1 Netural 5 Pending 2 Acsident investigation | Ba. Deta of Injury (Month, Dey Yea | 28b. Time (Injury | ot M | 28c. Injur Wor 1 □ | yat k? Yes 2 □ No | 28d. Describe | how injury occur | red | | | | | |
| Division | 무취중도 | Certification: | 3 ☐ Suicida 6 ☐ Could not be datermined 28 | sa. Piaca ot Injury - building, etc. (Sp | At home, farm, s pecify) | treet, facto | ry, office | | | Street and Numl wn, State) | ber or Rura | l Routa Number, | | | | |
| | To the Hospital within 24 hours a To the Funeral Completaly filled | edical | 29a. Certifier (Check only one) Stiffying Physician (Check only one) | n: To the best of my the basis of examination manner stated. | knowledge, dea minati <i>on</i> and/or i | th occurred nvestigation | at the tir | ne, data and place, pinion, daath occur | , and dua to the rred at the time, | cause(s) and madata and place, | annar as st and due to | ated. the cause(s) | | | | |
| | To the To the comp | 29b. Signsture and title of certifier 29c. Licensa eury/ber 29c. Licensa eury/ber 29d. Date signed (Month, Day, Year) | | | | | | | | | | Oay, Year) | | | | |
| | | | 30. Name and address of person who comple | ted cause of death | (Item 23e) (Type | , Print) | | | | | 1 | | | | | |
| | | | Peter R. Graze, M.I | | | Road . | Annaı | oolis, Ma | ryland | 21401 | | | | | | |
| | Sta | | 31. Data tiled (Month, Dey, Year) AIIC 4 0 1007 | 32. Registrar's S | | 4 - | | | | | | | | | | |

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State of Maryland / Department of Health and Mental Hygiene 97 27232

| why injury or other traumatic event, the Medical Examinating the Injury or other traumatic event, the Medical Examinating the Injury or other traumatic event, the Medical Examinating the Injury or other traumatic event, the Medical Examinating the Injury or other traumatic event, the Medical Examinating the Injury or other traumatic event in the Injury or other traum | Sara H. Shockle 4a. Facility Name (If not institution, gi Genesis Elder Car 5. Social Sacurity Number 6. 214-38-2030 Usual Residence of Decedant 10a. State 10b. County Maryland Anne Art 10e. Street and Number | ey ive street end number) ce Spa Cree | (In yrs. lest birth | nday) If Un | | 4b. City, Tow | | 2. Date of Dec Month August action of Death | 13, 19 | | | of Death |
|--|--|---|--|------------------------------|--|-----------------|-----------|--|---------------------------------------|----------------|---|-------------|
| /Medical ixaminer neral ector | Sara H. Shockle 4a. Facility Name (If not institution, gi Genesis Elder Car 5. Social Sacurity Number 6. 214-38-2030 Usual Residence of Decedant 10a. State 10b. County Maryland Anne Art 10e. Street and Number | re Spa Cree Sax 7. Age | (In yrs. lest birth | | | 4b. City, Tow | | August | 13, 19 | 97 | 6:5 | 55 pm |
| neral ector | 4a. Facility Name (If not institution, girls Genesis Elder Car 5. Social Sacurity Number 6. 214-38-2030 Usual Residence of Decedant 10a. State 10b. County Maryland Anne Art 10e. Street and Number | re Spa Cree | (In yrs. lest birth | | | 4b. City, Tow | n, or Loc | ation of Death | 4c. Count | v of Death | | Pill |
| ector | 5. Social Sacurity Number 6. 214-38-2030 Usual Residence of Decedant 10a. State 10b. County Maryland Anne Art 10e. Street and Number | Sax 7. Age | (In yrs. lest birth | | | | | ACMINI NEED | | , | | |
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| by Funeral Director | Usual Residence of Decedant 10a. State 10b. County Maryland Anne Art 10e. Street and Number | TUM ZUALT | M 2 XF 81 Yrs. Months C | | | | 4 Hrs. | 6. Data of Birtl (Month, De) | h v. Year) | 9. Birtho | Birthplaca (Stata or Foreign Country) | |
| by Funeral | Maryland Anne Art | | 81 Y | rs. | | | | July 17 | 17, 1916 Maryla | | | |
| by Funeral | | | 10c. City, Town | or Location | | | | | | 1 | 0d. Inside | City Limit: |
| by Funeral | | undel | Arnold | | | | | | | | 1 □ Ye | 95 2X N |
| by Funeral | | didei | Millord | 10f. | Zip Code | | | | 10g. Citizen of | What Cour | ntry? | |
| þ | 1248 Maple Road | | | 21 | 012 | | | | United States | | | |
| þ | 11. Marital Status | 12. Was Decedent E Armed Forces? | Ever in U,S. | 13. Was De | ecedent of | Hispanic Origi | in? (Spec | cify Yas or No- | 14. Rac | an Indian, | | |
| ed by | | 1 ☐ Yas 2 ☒ N If Yas, Give | lo | | s 2 No | | T dano 1 | iloan, ato., | Black, White, etc. Specify: Caucasia | | | |
| d | 3 Widowed 4 □ Divorced | Yaar or Datas: | | | | ороспу. | | | Specii | y Cauc | casia | 11 |
| 0 | 15. Decedent's E (Specify only highast gr | Education rade completed) | (| Decedent's U Giva kind of | work done | during most | of workin | g | 16b. Kind of Business/Industry | | | |
| Completed | Elementery/Secondery (0-12) | Coltege (1-4or 5 | +) | life. DO NO | T use retire | ed) | | | | | | |
| Co | 17. Father's Name (First, Middle, Las. | 4 | Tea | acher_ | | 18 Mathari | 'e Namo | /First Middle | Academic , Middle, Meiden Sumeme) | | | |
| Be | | 4 | | | | 76 | | | Meiden Sumer | | | |
| P | George Hayward 19a. Informant's Name/Relationship | (Time Point) | 10b l | Mailing Addr | ross /Stens | Lulu M | | | nber, City or Town, Stete, Zip Co | | | |
| | Patrick Shockley | (Type, Franc) | | | | | | | , Penns | | 9380 | |
| | 20a. Method of Disposition | | 20b. Place of D | Disposition (| Neme of | | | Data | 20c. Location | | | ,500 |
| | 1 Burial 2 Cremation 3 | | cemetery, | , cremetory | or other ple | | 100 | A COLUMN | | | | |
| | 4 Donation 5 Other (Special Service Lice | | Bates P | | | ess of Fecility | | 5/18/9/ | Snow H | 1111, | Mary. | land |
| | | 1 | 1 | John | M To | vilor F | | al Home | e, Inc. | 147 | Duke | of (|
| - | 23 Part Efilar the diseasa, or un shock, or heart failure. List only | (X) 0 | Le, | Houc | ester | Stree | t An | napoli | s, Mary | land | 21401 | |
| - | shock, or heart failure. List only | one cluse on each tin | e. | it anter the n | node or dy | ing, such as c | ardiac or | respiratory an | rast, | 1 | Approxima Interval Be Onset apo | etween |
| - | immediate Causa (Final | | Lles | nA | 6 | · Ou | _ | | | | 6/1 | , Douter |
| | disease or condition resulting in deeth) | a | Oue to (or as a co | | 1 | ~ | , | | | | 600 | _ |
| Jer. | 1 | ľ | | | | | | | | | | |
| Examiner | Serversially list assethings | b | Due to (or as a co |) (Y | 00: | - | | | | i | | |
| Exa | Sequentially list conditions, if any, leading to Immadlate cause. Enter Underlying | | oue to (or as a co | ilaequerice (| 01). | | | | | | | |
| edical | Cause (Disease or injury thet initiated events resulting in daath) Last | c | oua to (or as a cor | nsequenca d | of): | | | - | | | | |
| /Med | 105 URING III Gaatii) Last | | · | | | | | | | | | |
| | | d | | | | | | - | | | | |
| Physician | Part It. Other significant conditions of | contributing to death bu | t not resulting In t | he underlyin | ng cause gi | ven in Pert i. | | 23b. Did to | obacco use co | ntribute to | the cause | of death |
| | | | and the desired section of the desired section of the section of t | | | | | | 7es 2□ No | | | |
| by | | | | | | | | | | T | | |
| Completed | | | | | | | | 24a. Was a perfor | | avi | ere autopsy aiiable prior mpletion of | rto |
| du | | | <u>-</u> | | | | | | Α. | of | death? | Cause |
| S | | | | | | | | 1 🗆 Y | es avo No | 10 | Yes 2 | □No |
| Be | | 460173414 | | | | | of Deeth | (Check only or | ne) | | | |
| To | | Hospital: 1 Inpatier | - | atlent 3 | DOA | | sing Hom | e 5 🗆 Resid | ence 6 Oth | er (Specif | y) | |
| on: | 27. Menner of Death 1. Natural 5 Pending | 28a. Date of injung (Month, Dey | Year) 28b. Tin | ury | 28c. inju Wo | | | 8d. Describe h | ow injury occur | red | | |
| cat | 2 Accident investigatio | 10 | | М | | Yes 2□N | | | | | | |
| Certification: | 4 ☐ Homicide determined | 28e. Pieca of inju- building, etc. | ry - At home, farm (Specify) | n, street, fact | at, factory, office 28f. Location (Street and Number or Rural Route Number of City or Town, State) | | | | | m <i>ber</i> , | | |
| | | Dhysician. To the heat of my translating death accuracy at the time date. | | | | | | | | | | |
| edical | 29a. Certifier (Check only onl) Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. Check only only Medical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| Me | | and manner stat | / | - 13 | 29c, Licens | se number | | | 29d. Data signe | d (Month | Day. Yearl | |
| (| DALL VE | certifier 29c, License number D21438 | | | | | | | August | | | |
| | 1000 | 0,0 | ~ (1) | | 1/214 | 30 | | | august | 14, I | 231 | |
| | 39. Name and address of pegen who | | | | Δ. | | | 7 - 2 | MD O | 1 101 | | |
| | Michael J. LaPent | a, M.D. 6 | 00 Rido | gley | Aven | ue, A | nnaj | oolis, | MU 2 | 1401 | | |
| | 31. Dete filed (Month Play Year) | JE. HUUIS(fal | - Similarnia | | | | | | | | | |
| ate rar | 31. Dete filed (Month, Dey, Year) AUG 1 9 19 | | Davidson) | n | | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene Q 7

| | | | | C | ertificate of | Death | F | leg. No. | 1 | 21233 |
|------------------------|---|-----------------------|--|-----------------|---|-------------------------------------|-----------------------------------|-------------------------------------|--|--|
| | | | Decedent's Neme (First, Middle, Last) | | | | 2. Dete of Dee | | Yeer | 3. Time of Death |
| | Physici /Medi | cal | Alva Thurman Shult: | Z | JR. | 4b. City, Town, or L | August | | 997 | 1510 |
| _ | Examir Funeral Director | | Genesis Elder Care Spa (5. Social Security Number 6. Sex 7. Age (in yrs. last 1 X M 2 F 7. 5 | | Creek Annapol birthday) if Under 1 Yeer If Under 24 Hrs. Months Deys Hours Min. | | | | neArundel 9. Birthplece (State or Foreign Country) Portsmouth, 0 | |
| | ithin 72 hours after death with the Maryland e.e. an "natural", or items 23a or 28a-f show I Medical Examiner must be notified at | by Funeral Director | Usuel Residence of Decedent 10e. Stete 10b. County 10c. | City, Town o | r Location | 7 | | | 1 | I0d. Inside City Limits 110 Yes 2 □ No |
| | | | 10e. Street and Number | Annap | 10f. Zip Code | | | 10g. Citizen of V | Vhet Cour | ^ |
| 121215-0020 | | | 9 Dewey Drive | | 2140 | | - W. W | USA | 8 | and the state of |
| | | | 11. Meritel Stetus 1 □ Never Merried 2♥ Merried 3 □ Widowed 4 □ Divorced 12. Wes Decedent Ever in Armed Forces? 13. Wes Decedent Ever in Armed Forces? 14. □ Yes 2 □ No fil Yes, Give Year or Dates: | 10,5. | 13. Was Decedent of Hif Yes, specify Cub1 ☐ Yes 2 No | anic Origin? (Spen, Mexican, Puerto | pacity Yes of No- Pican, etc.) | Blac | k, White, | |
| | | Completed | 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) | 16a. De (G | ecedent's Usuel Occup iive kind of work done e. DO NOT use retire | pation during most of world) | king | 16b. Kind of Bu | siness/in | dustry |
| | filed within Hyglene. ther than " | To Be Cor | 3 | Ti | tle Super | | | State | | MD |
| anc | Mental Farked of | | 17. Fether's Neme (First, Middle, Last) Alva Shultz | | | 18. Mother's Nerr | ne (First, Middle, | | Θ) | |
| Maryland | and and series | | 19e. Informent's Neme/Reletionship (Type, Print) | 19b. M | elling Address (Street | | | | State. Zir. | Code) |
| | | | Georgina E. Shultz | | Dewey Di | | | | 21 | |
| altimore, | | | | | sposition (Name of cremetory or other pie | ce) | Dete | 20c. Location - | City or To | wn, State |
| Ĕ | permit. Pages 1 a Department of Hee Important: If item any injury or othe | | 1 Buriel 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) MD. Veterans Cemetery 8/18/97 Crownsville, MD | | | | | | | |
| alt | | | 21 - Bignature of Funeral Service Licansee | | 22. Neme end Addre | ess of Fecility | | | | |
| œ | 8979 | | Dareld S. Juy For | | | . Taylor | | | ie, : | INC. |
| П | | | 23e. Part1. Enter the disease, or complications that caused the deshock, or heart feiture. List only one cause on each line. | eath. Do not | ente The mode P Bin | ng soctyas cardiac | or respiratory at | rest, | i | Approximate Intervel Between |
| 9 | Physician /Medical Examiner | | Immediate Ceuse (Finel disease or condition resulting in deeth) Arteriosclerotic heart disease years | | | | | | Onset and Deeth | |
| | | | | | | | | | years | |
| | | ě | Due to (or es a consequence of): | | | | | | | |
| o, | ntificate be executed og physician and as the burial-transit | i Examiner | Sequentieily list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury | o (or es e cor | e consequence of): | | | | | |
| 68760, | hysic the b | edicai | | (or es e con | | | | 1 | | |
| Box 6 | E 8 a | S . | | | | | - | | | |
| of Vital Records, P.O. | deat he att | Physician/ | Pert II. Other significant conditions contributing to death but not r | resulting In th | e underlying cause glv | ven In Pert I. | 23b. Did to | obacco use cor | ntributa te | o the cause of death? |
| | v requires that the death ce been signed by the attendi should be detached for use | by Phy | Diabetes wellitus, Hy | pert | ntension, | | | □ Yes 2 No 3 □ Probably 4 □ Unknown | | |
| | N 50 | Completed | Multiple cerebral in | nfarc | | | | dormed? available pri | | ere autopsy findings allable prior to impletion of cause deeth? |
| | | Be | | | | | 1 🗆 Y | es 2 No | 10 | ☐ Yes 2☐ No |
| | | | 25. Wes case referred to medical examiner? Leavise: 26. Place of Death (Check only one) | | | | | | | |
| | Physic this c | -T | 1 Yes 25 No Hospitel: 1 Inpatient 2 ER/Outpetlent 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Menner of Deeth 28e. Dete of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred | | | | | | | |
| | h. After fune | tion | Natural 5 Pending (Month, Dey Year) |) Inju | ry Wo | rk? Yes 2 No | 200. Describe II | ow injury occurr | 90 | |
| | To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificata ha completaly filled in by the funeral director, page | edicai Certification: | 3 Suicide 4 Homicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | ni Route Number, | |
| | | | 29a. Certifier (Check only one) Cartifying Physician: To the best of my knowledge, death occurred at the time, dete and pleca, end due to the ceuse(s) and manner as steted. Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner steted. | | | | | | | |
| | To t To t | W | 29b. Signeture end title of certifier Charles W, Kinn DO 5928 29c. License number 29d. Dete signed (Month, Day, Year) 4 rays \$14,1997\$ | | | | | | | |
| | | | 30. Name and address of parson who completed cause of deeth (Item 23a) (Type, Print). Charles W. Kinzer, MD, 2003 Medical Pkwy #100, Annapolis, MD 21401 | | | | | | | |
| | Sta Registr | | 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture 32. Registrer's Augustus Andrew 33. Registrer's Signeture | | | | | | | |
| DU | IIII 46 Day 60 | eat . | HOG 1 9 1991 January | A CONTRACTOR | | | | | | |

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

27234 AMEND # 8 cms 8/27/97 AA CO Health Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month **Physician** Kathlean M Sanford 1997 11 4:12PM August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2XX Yrs. Director 424-24-7312 March 20 1927 Alabama Usual Residence of Decedent with the Marylend 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits rst', or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Florida Webster Sumter 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5228 County Road, 683 33597 United States death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2☐ No If Yes, Give X Year or Dates: 11 Marital Status Was Decedent of Hispenic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, Whita, etc. Pages 1 end 2 should be filed within 72 hours efter to nent of Health and Mental Hygiene. Int: If Item 27 is merked other then "naturst", or item 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: White **3**DXWidowed 4 □ Divorced Completed traumatic event, the Mazical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Henry Mixon Netter Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other train 725 Fairway Drive Annapolis, Maryland 21401 Linda S. Cochran (Daughter) 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removel from State
4 □ Donation 5 □ Other (Specify) permit. Page Department of Important: If any Injury or once. Seffner Cemetery August 15, 1997 Seffner, Florida 21. Signature of June 11 Source Licen 22. Name end Address of Facilityohn M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart tailure. List only one ceuse on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physicien end s the buriel-transit The law requires that the death certificate be executed Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last P.O. Box 68760, Physician/Medicai ettending for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown d be det Records, à 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? tes completion of cause of death? ate hes 2 X No 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifica stelly filled in by the funeral director, I Be 25. Was case reterred to medical examiner? 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 inpatient 2 □ ER/Outpetient 3 □ DOA 27. Menner of Death 28d. Describe how Injury occurred 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 5 Pending Investigation Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours ele To the Funeral D completely filled it Medical Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. 29a. Certifier 29b. Signature and title of certifier 29d., Date signed (Month, Dey, Year) 29c. License number 2003 Medical Pkwy #100, Annapolis, MD 32. Registrer's Signature 31. Date tiled (Month, Day, Year) State AUG 1 Registrar 9 1997

DHMH 16 Rsv 6/95

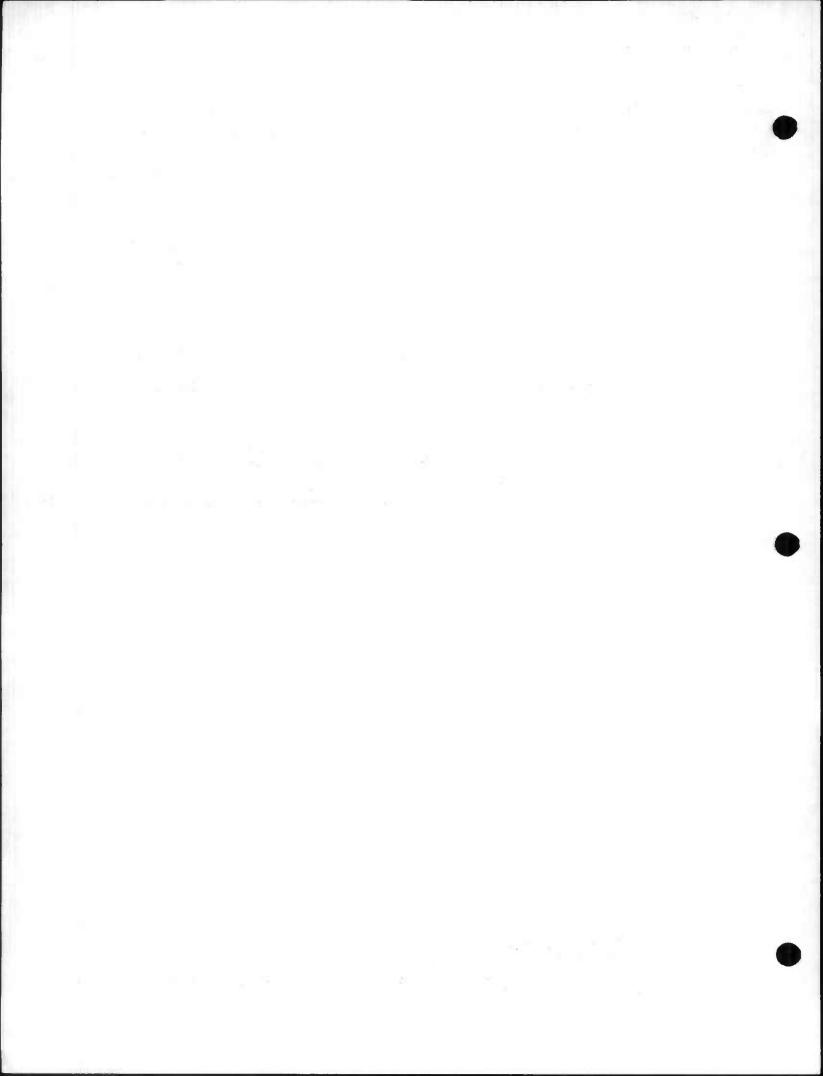
| | | | EVIN SPALDING | | 0- | artment of I | | Mental Hy | | 7 27235 |
|------------|--|------------------|--|--|---------------------------------------|---|---|--------------------------------------|--|--|
| | I CCIIIS . Z | امر | art I,27,28a-f per MEO 1. Decedent's Name (First, Middle, Las | | un | | | 2. Date of De | | 3. Time of Death |
| 3 | Physic | | Joseph Kevin | Spalding | | | | AUG. | 11, 1997 | 5:10 PM |
| | /Medi Examii | | 4a. Facility Name (If not Institution, give 214 CEDAR HILL A | | | | 4b. City, Town, or GLEN BU | Location of Deal | h 4c. County | |
| | Funeral Director | | 5. Social Security Number 6. Security Number 217-84-6231 Usual Residence of Decedent | 7. Age (In) XM 2□ F 35 | rrs. last birthday Yrs. | If Under 1 Year Months Days | | . (Month, Di | th ay, Year) 8, 1962 | 9. Birthplace (State or Foreign Country) Washington, D.(|
| | a-f show | otor | 10a. State 10b. County Maryland Anne Art | | City, Town or L Glen Bu | | | | | 10d. Inside City Limits 1 ☐ Yes 2 ☒ No |
| | death with the Marylar me 23a or 28a-f show r.must be notified at | ral Director | 10e. Street and Number 214 Cedar Hill Av | renue | | 10f. Zip Code 2122 | 5 | | 10g. Citizen of W United of Amer | |
| 020 | ar, or he Examine | by Funeral | 11. Marital Status 1 🛣 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorcad | 12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No lt Yes, Give Year or Dates: | n U,S. 13. | Was Decedent of It Yes, specify Cub 1 ☐ Yes 2 ☐ No | | Specify Yes or No to Rican, etc.) | 14. Race Black Specify: | - American Indian, K, White, etc. |
| 21215-0020 | i within 72 hours jene, r than "natural", the Medical Exe | Completed | 15. Decedent's Edi (Specify only highest grad Elementery/Secondary (0-12) | ucation fe completed) College (1-4or 5+) | | edent's Usual Occup e kind of work done DO NOT use retire | | orking | 16b. Kind of But | |
| 9 | TO 100 to 100 | | 17. Father's Name (First, Middle, Last) | | COII | Struction | | me (First Middle | Building Maiden Surname | 9 |
| Maryland | ould be file Mental Hy, arked othe atic event, | o Be | Robert L. Spaldin | g | | | | Innette | | 2/ |
| Ž | 2 shoul and Mi is mark aumati | ٩ | 19a, tntormant's Name/Relationship (T | | 19b. Meil | ing Address (Street | | | | State Zin Code) |
| | | | Esta Tippen Carro | | | Mauerto | | | uertown, | |
| Baltimore, | Pages 1 ant of He nt: If then ry or oth | | 20a. Method of Disposition 1 Burial 2 A Cremation 3 4 Donation 5 Other (Specify, | Removal from Stete | b. Place of Disponentery, cre | osition (Name of matory or other pla | ce) | Date August 14, 1997 | 20c. Location - 0 | City or Town, State |
| Balt | permit. Pa Departmen Important: any injury once. | | 21. Signature of Funeral Service Licans | work | D | 2. Name and Addre ellinger 57 North | ess of Facility Funeral | Home | | Virginia 22664 |
| | Physician /Medical | (| 23. First. Enter the disease, or comp shock, or heart teilure. List only of Immediate Cause (Finel disease or condition | ne cause on each line. | | iter the mode ot dyl | | | | Approximate Intervel Between Onset end Death |
| | Examiner | | resulting In death) | d | o (or es e conse | | | | | |
| 68760, | the death certificate be executed y the attending physician and sched for use as the bunel-transit | Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last | c | o (or es e conse | | | | | |
| Box | ath certification that the second sec | lan | | d | | | | | | |
| P.O. | es that the dea gned by the at be deteched for | by Physician/Med | Part II. Other eignificant conditions co | ntributing to death but not | resulting In the u | ınderiying cause gi | ven in Part t. | | | tribute to the cause of death? 3 Probably 4 Unknown |
| Records, | aw requin | Completed b | | | | | | 24a. Was | en eutopsy ormed? | 24b. Were autopsy tindings available prior to completion of cause of death? |
| E R | The ate h | Con | | | | | | 10 | Yes 2□No | 1 Yes 2 No |
| Vital | Physician: The this certificate ral director, page | Be | 25. Wes case reterred to medical examiner? | Hospital:, | | OH | | ath (Check only | one) | |
| o | this al di | . To | XXYes 2 No 27. Manner of Death | 1 L Inpatient 2 | 28b. Time of | nt 3LI DOA | | 7 | denca 6 Othe | |
| | ing After fune | tion | 1 ☐ Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day Year | | Wo | rk? Yes 2(00)No | | how Injury occurre | 9d |
| Division | Atten r deel ctor: y the | Certification: | 2 Accident 3 Suicide 4 Homlcide | found 8/11/97 28e. Place of Injury - A building, etc. (Spe at residence | found 4 t home, farm, st ecify) | .00 | WW. | City or To | Street and Numbe wn, Stete) 214 (| or or Rural Route Number, Cedar Hill Lane, |
| | To the Hospital or within 24 hours efter To the Funeral Director Completely filled in the complete of the comp | edicai C | 29a. Certifier (Check only one) 1 Certifying Phy XX Medicat Exami | elctan: To the best of my liner: On the basis of exam and manner stated. | nowledge, deet ination and/or in | h occurred at the til evestigation, in my o | me, dete end plec oplnion, death occ | e, end due to the | ceuse(s) and mar | nner as steted. |
| | To the within 2 To the comple | M | 29b. Signature and title of certifier | 11 | | 29c. Licens | | | | (Month, Day, Year) |
| | | - | 30. Name and address of person who co | moleted caus of death // | tem 23a) /Tuna | | C.M.E | | AUG. | 12, 1997 |
| | | | THEODORE | UKing | A | 111 Pe | enn Stree | et, Balt | imore, M | aryland 21201 |

State Registrar 31. Date filed (Month, Dey, Year)

AUG 2 1 1997

AUG 2 1 1997

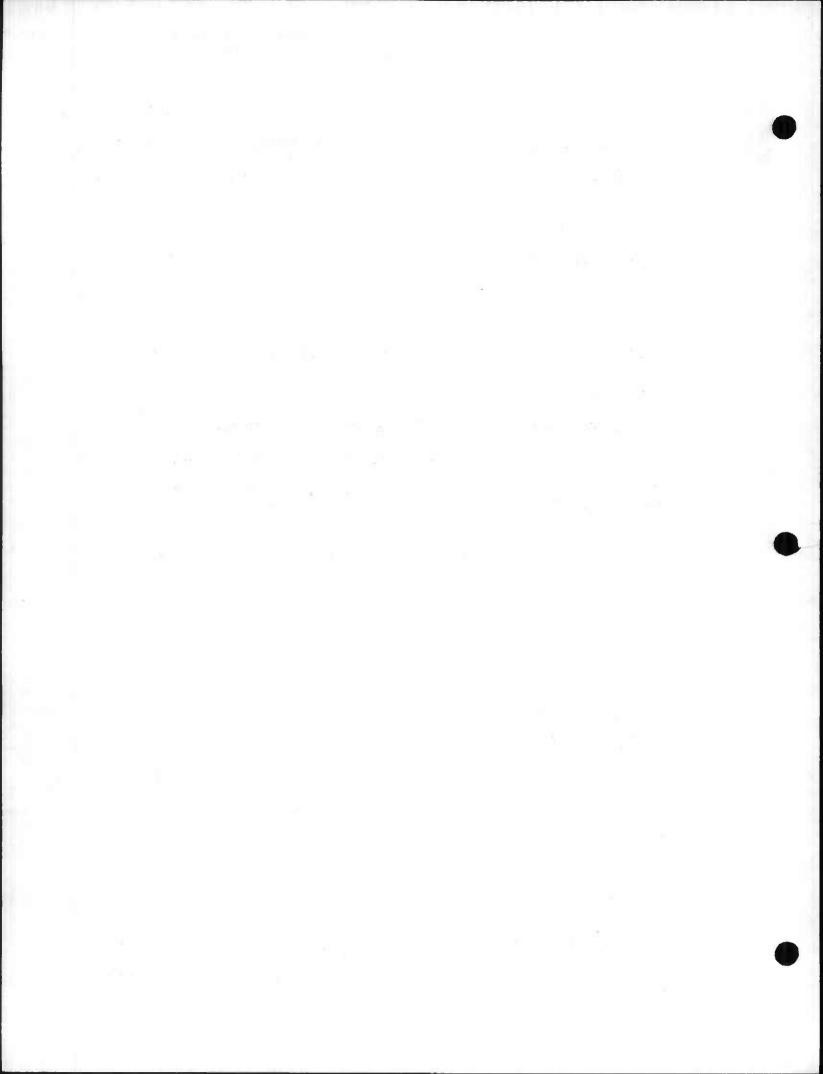
AUG 2 1 1997



State of Maryland / Department of Health and Mental Hygiene 97 27236

| | | | | | | Ce | rtificat | e of | Death | | F | leg. No. | | | |
|------------|--|----------------|---|---|--|-----------------|----------------------------------|-----------------|-----------------------|----------------------------|---------------------------------|-----------------------------|--------------------------------|------------|----------------------|
| | | | 1. Decedent's Neme (First, Middle, | Last) | | | | | | 1 | 2. Data ot Dee | th | whi. | 3. Tim | e of Death |
| | Physici | | DOLLY SCHAR | F | | | | | | | Month AUG 19 | Dey 9 1997 | Yaer | 12. | 20 pm |
| 9 | /Medi Examir | | 4e. Fecility Name (If not Institution, | | r) | | | | 4b. City, To | | ation of Deeth | 4c. County | of Deeth | 143 | ZU DIII |
| | Exami | 101 | MERIDIAN SPA CR | EEK | | | | | ANNAPO | NT TC | | ANNE | ARUN | IDEI | |
| - | Funeral | | | | ge (In yrs. | lest birthday | If Under | 1 Year | If Under | | B. Dete of Birth (Month, Dey | | | | ta or Foreign |
| | Director | | 101-07-1698 Usuel Residence of Decedent | 1□M 2\\ F | 95 | Yrs. | Months | Deys | Hours | | (Month, Dey | | NEW Y | | ta or Foreign |
| | /land | | 10a. Stete 10b. County | | 10c. Cit | y, Town or L | ocation | | | | | | 1 | 0d. Insid | e City Limits |
| | the Marylar r 28a-f show | Director | MARYLAND ANNE AR | UNDEL | ANN | APOLIS | 10f. Zip | Code | | | 1 | log. Citizen of t | Whet Cour | | Yas 2□No |
| | ath with | ral D | 979 WINDWHISPER | | | | | 2140 | | | | US | | | |
| 020 | be filed within 72 hours effer death with the Maryland hal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | by Funeral | 11. Meritel Stetus 1 □ Never Merried 2 □ Merrier 3 ☒ Widowed 4 □ Divorced | 12. Wes Decedan Armed Forcas 1 ☐ Yes 2 ☑ If Yes, Give Year or Detes | ?] No | ,S. 13. | Was Dece It Yes, spe 1 Yas | | | gin? (Speci , Puarto Ri | ify Yas or No- ican, etc.) | | e - Amaric ck, Whita, /: | | |
| 5-0 | "natural", | ted | 15. Decedent's (Specify only highast) | Education | | 16e. Dece | dent's Usu | el Occu | petion during most | of working | 7 | 16b. Kind of B | usiness/in | dustry | |
| 21215-0020 | should be filed within of Mental Hygiene. marked other than "r | Completed | Elementery/Secondary (0-12) | College (1-4o | yrs. | life. | DO NOT u | se ratire | DESIGN | | | SELF 1 | EMPLO | YED | |
| | Hygie Ther Ther | | 17. Fether's Neme (First, Middle, La | | , - 0 - | | | | 1 | | First, Middle, | Meiden Suman | | 100 | |
| Maryland | Mental Mental arked o | To Be | I OUTC OFFMAT | NT. | | | | | | | | | | | |
| 7 | 2 should end Men a marke | - | LOUIS GERMAI 19e. tntorment's Neme/Relationship | | | 19b. Maili | ing Address | (Stree | _ | DA | Route Numbe | r, City or Town, | Stete Zin | Code) | |
| X | 2000 | | ROBERT SCHARF (S | | | | _ | | | | | | | | |
| a) | 1 and Health em 27 other tr | | 20e. Method of Disposition | ON) | 20b. F | Plece of Dispe | osition (Ner | ne of | | ET ANI | Deta Deta | MD. 20c. Location | | | 9 |
| Baltimore, | | | 1 ☐ Burial 2X☐ Cremetion 3 | | 8 | TRO CF | | | ca) | 01 | 21/07 | BALTIMO | | | |
| Itin | it. P | | 4 Donetion 5 Other (Spe | | ME | | | | | | 21/9/ | PALITMO | XE, M | υ. | |
| Ba | permit. Pages 1 a Department of Hea Important: If item any Injury or othe | | 21. Signeture of Funeral Service Lie | M. Xu | Ses | 2 h | M. RE | EESE | | IS MOI | RTUARY, | | | | |
| | | | 23e. Part1. Enter the diseasa, or co | implications that cause | ed the deat | h. Do not en | 321 WE ter the mod | ST le of dyi | ST. All | INAPOI cardiac or | LIS, MI respiretory err |). 2140. est, | L. | Approxi | mete |
| | Physician | | shock, or heert teilure. List or | lly one ceuse on eech | lina. | | | | | | | | į | Onset e | Between and Deeth |
| | /Medical | | tmmediete Cause (Finel | 0 | 0. (| 20 01 | | 4 | on t | | faile | 111 | | | |
| | Examiner | | disease or condition resulting in deeth) | в | | es e conse | | | eur. | | por | | 1 | YR | |
| _ | | ē | | | Due to (© | es e conse | quence oi): | | | | () | | 1 | | |
| | tificate be executed ig physician and es the buriel-transit | Examiner | Daniel Market Market | b | Due to (e | r es a conse | augaga at\ | | | | | | 1 | | |
| Ć, | exec n an | Exa | Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury | | D00 10 (0 | es a conse | quence oi). | | | | | | 1 | | |
| 68760, | lew requires that the death certificate be executed as been signed by the attending physician and be Schould be detached for use as the burlet-transit | | Cause (Disease or Injury thet Initieted events | c | Due to (e. | | | | | | | | - | | |
| 68 | ficate phy s the | Medical | resulting in deeth) Lest | | Due to (o | r es e consec | quence ot): | | | | | | | | |
| × | certifi ding | Ž | | d | | | | | | | | | | | |
| Bo | attend | ciai | | | | | | | | | | | | | |
| 0 | that the de ed by the detached | Physician/ | Part II. Other significant conditions | contributing to death | but not res | ulting in the u | inderlying o | ause gi | ven in Part I. | | | obacco use co | | | |
| 0 | that the ed by detac | | Queun | one | | | | | | | 1 U Y | ee 21 No | 3 Pro | bably 4 | 4 Unknown |
| Records, | ires tha signed d be de | l by | Romein | A | | | | | | | 04-144 | | 7.4h W | ara autar | as timalinas |
| 0 | requir been s should | Completed | Olemen | lic | | | | | | | 24e. Wes e perfor | med? | av | ailebia pr | |
| ec | has b | du | | | | | | | | | | 2/ | ot | deeth? | 1 |
| = | E ag ag | S | | | | | | | | | 1 🗆 Y | es 22 No | 10 | □Yes | 2D No |
| Vital | Physician: The ribis certificate ral director, pag | Be | 25. Wes case referred to medical exeminer? | | | | | | 28. Place | ot Deeth (| Check only or | ne) | | | |
| of \ | 5 00 | 2 | 1 Yes 2 No | Hospitel: 1 ☐ Inpai | tient 2 🗆 | ER/Outpetie | nt 3□ DC | DA Ot | ner: 4 Nu | rsing Home | e 5 Resid | ence 6 Oth | er (Specif | y) | |
| 0 | en the remainder | | 27. Menyrer ot Deeth Neturel 5 Pending | 28e. Date of In (Month, D | jury ev Year) | 28b. Time of | of 2 | 28c. Inju Wo | ry et | 28 | d. Describe h | ow Injury occur | red | | |
| 0 | Attending ir death. ector: After by the fune | atic | Accident investigat | ion | | | М | | Yes 2□! | No | | | | | |
| Division | To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral | Certification: | 3 Suicide 6 Could not determine | A 286. Place of It | njury - At ho etc. <i>(Specif</i>) | ome, term, st | reet, tector | y, offica | | 28 | St. Location (S City or Tow | treet and Numb n, Stete) | per or Rure | I Route I | Vum <i>ber</i> , |
| _ | To the Hospital or within 24 hours efter To the Funeral Director Completely filled in | | 29e. Certifier Certifying | Phyalcian: To the bes | t ot my kno | wiedne dest | h occurred | at the ti | me dete en | d piece es | id due to the o | suco(e) and m | anner ee e | tated | |
| | 24 h | edical | | aminer: On the basis | of exemine | tion end/or in | vestigetlon | , In my | pinion, daa | th occurred | et the time, o | lete and plece, | and dua to | tha cau | sa(s) |
| | ithin mpl | Me | 29b. Signatura and title ot certifier | ^ | | | 290 | c. Lican | se number | | 1 2 | 9d. Data signe | d (Menth. | Day. Yes | (r) |
| | F ≱ F 8 | | MAMA | C (Va) | 11- | | | - | / | Y | | 8/7 | 15 | 1 | |
| | | | 7/0010 | in and |) | | |)d' | 110 | 0 | | 0/2 | 11' |) | |
| | | | 30. Neme end eddress of person wh | o completed cause of | | | Print) | No | 176 12 Ly | 1 4 | WE | An | NAO | POL | 13 |
| | | | DAYSYS WM | A. | | 000 | 1/1 | 20 | ردار | /7 | 1 | /// | 10 110 | | |
| | Sta | te | 31. Dete filed (Month, Dey, Year) | 32. Regis | trer's Signe | ture | | | | | | | | | |

DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Yaar **Physician** JAMES PERCY SHORTALL 24, 1997 4c. County of Death August /Medical 3:00 PM 4a. Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death Examiner Memorial Hospital @ Easton
If Under 24 Hrs.
Hours Min. Easton Talbot If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 1**X**) M 2□ F Months Days Yrs Director 217-36-0692 Sept. 18, 1929 Maryland Usuai Residence of Decedent the Marylend permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Marylan Department of Health and Mantal Hygiane. Important: If item 27 is marked other than "naturel", or items 23s or 28s-f show sony injury or other traumetic event, the Medical Examines must be notified at once. 10e. Stata 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8386 Old Bloomfiels Rd. U.S.A. 21601 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Black, White, etc. Was Decedant of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1 Never Married 2 Married 1 ☐ Yas 2 ☑ No If Yes, Giva Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White <u>ک</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Hatchery Conagra 17. Fether's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) James Percy Shortall Sr. Florence M. Mielke 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Mary D. Shortall Wife 8386 Old Bloomfield Rd. Easton, Maryland 21601 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ∑Burial 2 ☐ Cremation 3 ☐ Removal from State Spring Hill Cemetery Aug. 27, 1997 4 ☐ Donation 5 ☐ Other (Specify) Easton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Addrass of Facility Harrison E. Leonard Funeral Home
312 S. Talbot St. St. Michaels, Maryland 21663

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest,

Approximate Approximate interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) COPD exaces bouton 24 hrs Examiner Due to (or as a consequence of): Examiner stage emphy attending physician and for use as the burish-transit certificate be executed Sequantially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that influeted events resulting in deeth) Last Physician/Medical Due to (or as a consequence of): P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 Nes 2 No 3 Probably 4 Unknown Records, ģ 24b. Were autopsy findings available prior to complation of causa of death? congestive heart failure 24a. Was an autopsy performed? Completed has 1 ☐ Yes 2 DNo 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitai: 1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred A Hospital or Attending P 24 hours after death.

Funeral Director: After t Certification: 1 Neturai 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyalclan: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) end menner as stated.

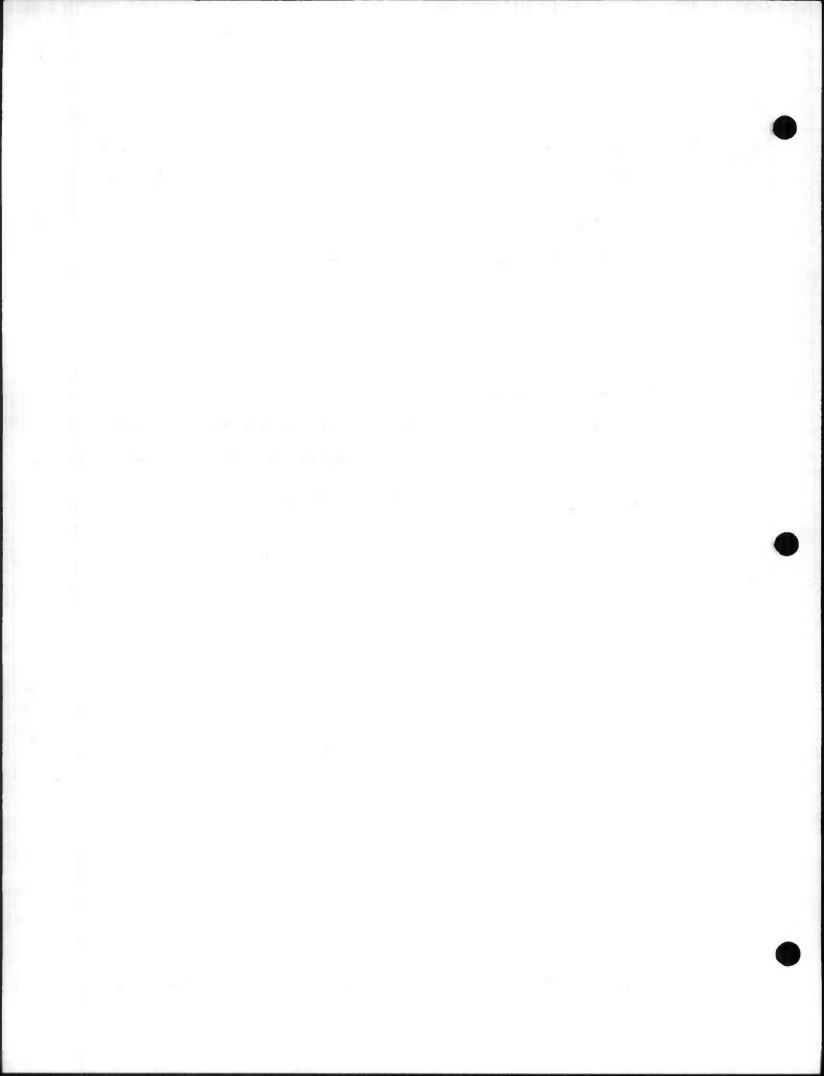
2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(a) and manner stated. edical 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. Licansa numbar 29d. Data signed (Month, Dey, Yeer) 30. Neme and address of person who completed cause of death (item 23e) (Type, Print) Peter L. Whitesell M.D. 508 Idlewilde Ave. Easton, Maryland 21601 31. Date filed (Month, Dey, Year) 32. Registrer's Signature

while Davidson-Randall.

DHMH 16 Rev 6/95

Registrar

AUG 26 1997



State of Maryland / Department of Health and Mental Hygiene 97 27238

| | | | | Cer | tificate of | Death | | Reg. No. | | 21200 |
|------------|---|-----------------|---|------------------------------------|--------------------------------------|--------------------------------|--|------------------------------------|--------------------------|--|
| | Dharalai | | Decedent's Name (First, Middla, Last) | | | | 2. Data of Month | Death | Voor | 3. Tima of Death |
| | Physici /Medic | | Russell L. Smith | | | | Augus | t 25 19 | 99 ⁷ | 1050 |
|) | Examir | ner | 4a. Facility Nama (If not institution, give street and number) | -1 | | | m, or Location of De | | | |
| | | Н | Carroll County General Hospit 5. Social Security Number 6. Sax 7. Aga (In yrs. | | If Undar 1 Yaa | Westmi | | Carro | | |
| | Funeral Director | | 217-28-7431 CS M 2 F 74 | Yrs. | Months Days | | Min. (Month, | Day, Year) . 20,1922 | 9. Birtho Cour Mar | placa (Stata or Foreign ntry) yland |
| | dand dand | | | y, Town or Loc | ation | | | | 1 | 0d. Insida City Limits |
| | Mary Hear | tor | Maryland Carroll Wo | odbine | | | | | | 1 ☐ Yas 2 ₺ No |
| | or 28 | Directo | 10e. Street end Number | | 10f. Zip Coda | | | 10g. Citizen of V | Vhat Cour | ntry? |
| | 23a | | | | 21797 | 7 | | United S | State | s |
| | Herman Merran | Funeral | 11. Marital Status 12. Was Decedant Evar in U. Armed Forcas? | ,S. 13. W | as Decedant of Yas, specify Cul | Hispanic Orlg ban, Maxican, | In? (Specify Yas or Puarto Rican, atc.) | No- 14. Raci Blac | e - Amaric k, Whita, | ean indian, atc. |
| 0200-61212 | 2 should be filed within 72 hours efter death with the Manyland and Mental Hyglene. Is marked other than "natural", or flems 23s or 28s-1 show surmatic event, the Medical Examinet must be notified at | þ | 3 5 Widowed 4 □ Divorced If Yas, Giva Yaar or Datas: WW I | I 1 | ☐ Yas 2⊠No | Specify: | | Specify | Whi | te |
| , D | 72 ho | Completed | 15. Decedant's Education (Specify only highast grada completed) | 16a. Deceda | ant's Usual Occu | upetion | of working | 16b. Kind of Bu | | • |
| 7 | vithin han | mpl | Elemantary/Secondary (0-12) Collaga (1-4or 5+) | | O NOT usa retir | | | Rosewood | d Sta Hospi | |
| 70 | Hygie ther t | | 8th 17. Fathar's Nama (First, Middla, Last) | Truck | Driver/ | T | | dle, Maidan Sumam | | .car |
| yland | ental ced o | To Be | Samuel E. Smith | | | | ie C. Buc | | ay | |
| mary | shou man | 1- | 19e. Informant's Name/Ralationship (Type, Print) | 19b. Malling | Addrass (Stree | et and Number | or Rural Route Nu | mber, City or Town, | Stata, Ziç | Code) |
| 2 | and 2 alth a 27 is | | Emma Gosnell Sister | 810 Da | avid Ave | e. Wes | tminster | MD 211 | 57 | |
| ore | of He | | 20a. Mathod of Disposition 20b. F | Place of Dispos comatery, cremi | ition (Nama of atory or other pla | ace) | Data | 20c. Location - | City or To | own, Sfata |
| pallimore, | ment ment lury | | 4 □ Donation 5 □ Othar (Specify) Mor | | pel Cem | | Aug. 28 | Woodbin | e, M | aryland |
| 0 | permit. Peges 1 and 2 should be filed Department of Health and Mental Hyg Important: If Itam 27 is marked other any injury or other traumatic event, any injury or | | 21. Signature of Funarai Sarvica Licansee | Bu. | Nama and Addr | ass of Facility | neral Di | rectors, | P.A. | |
| | 40200 | | Jana D Coverp | 12 | 12 W. O | ld Libe | rty Road | Winfield | d, MI | |
| Ų. | Dhysisian | | 23a. Part1 E star tha disaasa, or complications that caus if the built sho k, if heert feilure. List only one cause on each list. | Do not anta | r tha moda of dy | ring, such as c | ardiac or raspirator | y arrest, | | Approximata Intarval Between Onset and Death |
| | Physician /Medical | | imme date Causa (Finel | to M | IT | | | | 1 | |
| | Examiner | | disaasa or condition rasulting In daath) A Due to (c | or as e consequ | ance of); |) | | | - | |
| + | D # | iner | - Muo | Card | M K | LAN | MAO | | | 2HRS |
| | and I-trans | xam | Sequentially list conditions, if any, leading to immediate | or as a consequ | ance of): | 100 | 000 | | | |
| 00/00 | be exician buria | edical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events | | | | | | | |
| 00 | v requires that the deeth certificete be executed been signed by the attending physician and should be detached for use as the burial-transit | edic | rasulting in death) Lest | r as a consaqu | enca of): | | | | - | |
| 200 | h cert endin | M/ue | d | | | | | | | |
| 5 | he att | Physician/ | Part II. Other significant conditions contributing to death but not rase | ulting in the unc | darlying causa g | iven in Part I. | 23b. D | id tobacco use cor | tribute to | the cause of death? |
| | d by t | | Atrial Fibrulation | | | | 1 | Yes 2000 | 3 Prof | bably 4 Unknown |
| C, | signe d be d | d by | / OS | | | | 240 14 | les en autonou | 24h W | ara eutopsy findings |
| cords, | peen shoul | Completed | LOPP | | | | 24a. W | as an autopsy erformed? | ev. | allable prior to mpletion of cause |
| D | The law ate has b page 2 s | dmo | | | | | | □Yas 2MNo | | death? |
| | | Be Co | 25. Wes casa rafarred to madical | | | 26 Placa | of Death (Check on | | • • | 1 186 2 NO |
| > | 5 00 | To B | axaminar? 1 | ER/Outpatienf | 3□ DOA O | ther | | asidance 8 Othe | ar (Specif | y) |
| 5 | ng Ph fter th ineral | | 27. Mannar of Death 1 Netural 5 □ Panding 28a. Data of Injury (Month, Day Year) | 28b. Tima of Injury | 28c. Inju | ury at ork? | 28d. Dascril | be how injury occurr | bed | |
| | tendinestr. | cati | 2 Accident invastigation | | |]Yas 2□N | | | | |
| 5 | after d Direct J in by | Certification: | 4 Homicide detarmined 28a. Placa of Injury - Af hobuilding, etc. (Specifi | ma, farm, stre | at, factory, office | | 28f. Locatio City or | n (Street and Numb Town, Stata) | ər or Rura | al Routa Number, |
| | To the Hospital or Attending Physician: within 24 hours side deals as 16 deals filling to completely filled in by the funeral director, completely filled in by the funeral director, | edical C | 29a. Certifiar (Check only 2 Medical Examiner: On the best of my known to the | wledge, daeth | occurred at the t | ima, data and | place, and dua to t | he cause(s) end ma | nner as s | teted. |
| | the F | Med | one) and mannar statad. | NOT GROOT HITE | | | occurred at the till | | | |
| | 5 <u>₹ 5</u> 8 | - | 29b. Signatura and title of a filter | _ | N - | 394 | U 7 | 29d. Date signer | 7=1 | 07 |
| | | | 30. Name end address of person who complated cause of daath (Itam | 23a) (Time B | rinnA - 1 | 11 | 7 / | 8/ | 2) | 1/2 |
| | | | Scott Jeroma Do | 2112 | Make | Om | 2 116 | String | enl | 4D21157 |
| | Sta | te | 31. Data filed (Month, Day, Year) 32. Registrar's Signa | ture | | VIII. | V 1 V | 411111 | ,,, | |
| | Registr | ar | AUG 2 6 1997 Julk Davides | Mardall | | | | | | |
| DHN | AH 16 Rav 6/95 | 5 | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 27239

| | | | | | • | tificate of | Death | | ig. No. | 6. 1 Ci V | , , |
|-------------------|---|----------------|--|--|---|---|---|--|--------------------------------------|--|----------------|
| | Physic /Medi Examlı | cal | 1. Decedent's Neme (First, Middle, Last) Orpha ELizaba 4a. Fecility Name (If not institution, give street an | nd number) | eele | | 4b. City, Town, or Lo | 2. Dete of Deeth Month August calion of Deeth | Dey Y | Death | Death Su.M |
| | Funeral Director | | Fallston General Hos 5. Social Security Number 164-14-3230 6. Sex 1 M 2 | 7. Age (In yrs. la | est birthday) Yrs. | If Under 1 Yeer Months Deys | | 6. Dele of Birth (Month, Dey. Oct. 15 | Harfo (Year) 1920 V | ora Birthpiace (Stete or Country) Vest Virgi | Foreign nia |
| | Maryland a-f show | ctor | Usuel Residence of Decedent 10e. State 10b. County Maryland Harford | | Town or Local | ation | | | | 10d. inside City | |
| | ter death with the Marylan Items 23a or 28a-f show Inst. rount be notified at | al Director | 10e. Street and Number 603 Philadelphia Road | d | | 10f. Zip Code 2108 | 5 | 10 | og. Citizen of Who | et Country? | |
| 020 | n 72 hours efter death with the Maryland "natural", or liems 23e or 28a-f show edical Evantinet must be notified at | by Funeral | 1 Never Merried 2 Merried 1 1 If Ye | Decedent Ever in U,S ed Forces? Yes 2 TNo is, Give r or Detes: | | les Decedent of I Yes, specify Cub ☐ Yes 2 No | Hispenic Origin? (Sp an, Mexican, Puerto Specify: | ecify Yes or No- Rican, etc.) | | American Indien, White, etc. | |
| 21215-0020 | within ene. then - | Completed | 15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) Coile | eted) ege (1-4or 5+) | 16e. Decede (Give k life. De Homem | | pation during most of work d) | ing | Own Hom | | |
| | be filed tal Hyg d other | Be | 17. Fether's Neme (First, Middle, Last) | | | | 18. Mother's Nem | | - | | |
| Maryland | Mer Mer artic | To | William (NMN) Rigs | - | 40h Maltra | A dd (0 | Alice | • | sbury | | |
| | d2 sh ar | | John D. Steele - Husb | | | | end Number or Run Ohia Road, | | | | |
| Baltimore, | ages 1 and of He t: If item | | 20e. Method of Disposition 1 Spuriel 2 Cremetic 3 Removel 4 Donetion 5 Other (specify) | 20b. Ple cer | nce of Disposi metery, creme | ition (Neme of etory or other pla | | Dele 2 | 20c. Location - Ci | ty or Town, State | |
| Balt | permit. Page Department of Important: If any Injury or | | 21. Signature of Funeral Service Lifensee | 10 | 1 | 1317 Cok | . McComas esburv Ro | ad. Abin | adon. MI | | |
| 60, | Physician /Medical Examiner By physician and as the buriar-transit as the buriar-transit | ai Examiner | Sequentially list conditions, if any leading to immediate | EFT UPP Due to (or or | ER L es e consequ ER | OBE ence of): LoBE ence of): | _ | MAS | \$ | Approximate interval Between Onsel and D | reen |
| Box 68760, | th certificate ending physicals ruse as the | an/Medical | that initiated events resulting in death) Last | | is e conseque | ence of): | | | | | |
| P.O. | es that the death cer igned by the attendin be detached for use | by Physician/ | Part II. Other significant conditions contributing | to death but not result | ting in the und | dertying ceuse gi | ven in Pert I. | 23b. Did tol | | ibute to the cause of | |
| of Vital Records, | aw requires to seen s | Completed b | | | | | | 24a. Wes er perform | | 24b. Were autopsy fir aveilable prior to completion of ca of death? | |
| a H | Pa ate | | | | | | | 1□ Ye | s 201No | 1 Yes 2 N | No |
| ₹ | | To Be | 25. Wes cese referred to medicel exeminer? 1 Yes No Hospitel: | 1 inpatient 2 □ E | R/Outpatient | 3□ DOA OH | 26. Place of Deet | n (Check only one me 5 ☐ Reside | | (Specify) | |
| ion of | ing Ph I. After th funaral | | 27. Menner of Deeth 12 Neturel 5 Pending 2 Accident investigation | | 28b. Time of Injury | 28c. inju Wo | | 28d. Describe ho | | | |
| Division | To the Hospital or Attent within 24 hours effer death To the Funeral Director: completely filled in by the | Certification: | | Plece of Injury - At homouliding, etc. (Specify) | ne, førm, stree | et, fectory, office | | 28f, Location (Str City or Town | | or Rural Route Numb | er, |
| | To the Hospital or within 24 hours effe To the Funeral Dir completely filled in | edical | 29a. Certifier (Check only one) Certifying Physician: To Medical Examinar: On the end | o the best of my knowl he basis of examinetio menner steted. | edge, death on end/or inve | occurred at the tilestigetion, in my o | me, dete end piece, opinion, deeth occurr | and due to the ce ed et the time, de | use(e) end menn te end piece, and | er as steted. I due to the ceuse(s) | |
| | To t To t | Σ | 29b. Signature and title of pertifier | \rightarrow | - | 29c. Llcens | | | | Month, Dey, Yeer) | |
| | 10 | | Zemmy | Neur | Do | 144 | 1069 | P | rugust | 26, 190 | 17 |
| | 100 | | 30. Name and address of person who completed OR STANLEY KM 31. Dete flied (Month, Dey, Year) | JN 1308 | BUS | INCSS C | enter Wa | ay Suit | c 102 | 26, 190 Edgewood | 2 |
| | Sta Registr | | Aug. 2 7 1997 | 32. Riegistłar's Signatu | dall & | <i>x</i>) | | • | | • | |

DHMH 16 Rev 6/95

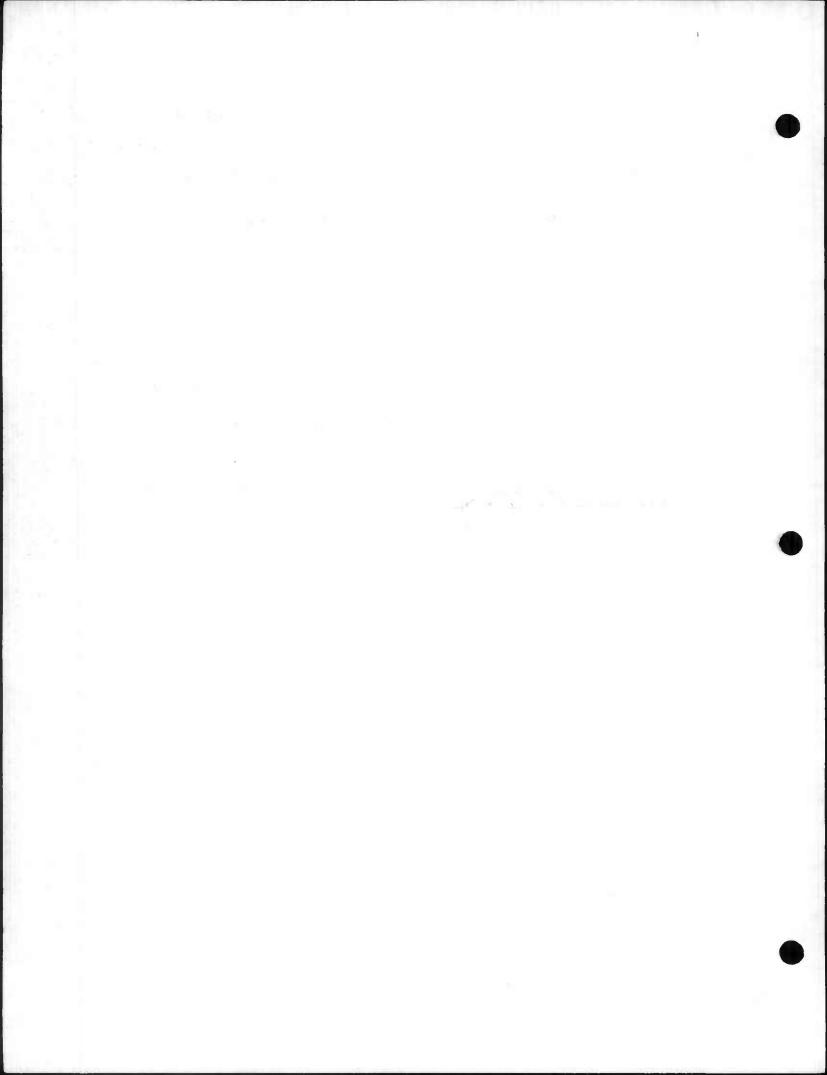
A . . =

State of Maryland / Department of Health and Mental Hygiene 9.7

97 27240

| | | | | | C | ertificate d | of Death | Re | g. No. | 1 6 | 1240 |
|---|--|---------------------|--|---|--------------------------------|--|---|---|--------------------------------|------------------------------------|---|
| | Dhualat | | 1. Decedant's Nama (First, Middla, Las | 1) | | | | 2. Data of Death Month | 1 | Yaar 3. | Tima of Death |
| | Physicia /Medic | | Jocelyn V | Silver | | | | August | Day 23 19 | 12.50 | 3:25 PM |
| | Examin | | 4a. Facility Nama (If not institution, give | street and number) | | | 4b. City, Town, or I | | 4c. County | | |
| | | | Citizens Nursing 5. Social Security Number 6. Se | ng Home | | W11-1-11 | Havre de | Grace | Har | ford | |
| | Funeral Director | | | 7. Aga (In) | rs. last birthde | Monthe Day | | 8. Data of Birth (Month, Day, 01-05-1 | 920 | 9. Birthplace Country) | (State or Foreign |
| land | M M | | 10e. Stata 10b. County | 10c. | City, Town or | Location | | | | 10d. le | nsida City Limits |
| death with the Meryland | Hed. | to | MD Harfo | ord | | Hav | re de Gra | ce | | 1 | ☐ Yas 2 No |
| th the | or 28 | irec | 10e. Street and Number | | | 10f. Zip Code | a | 10 | g. Citizan of V | What Country? | |
| ith wi | 23s | la | 130 Robin | Hood Road | | | 21078 | | | USA | |
| Te | natural", or items 23e or 28e-f show idical Examiner must be notified at | by Funeral Director | 11. Marital Status 1 □ Navar Marriad 2 □ Marriad 3 🗷 Widowed 4 □ Divorced | 12. Was Decedant Evar in Armed Forcas? 1 ☐ Yes 2 ☑ No If Yas, Giva | 1 U,S. 1 | 3. Was Decedani of If Yas, specify C | of Hispanic Origin? (Suban, Maxican, Puart No Specify: | pecify Yas or No- o Rican, atc.) | | a - Amarican Inck, Whita, atc. | |
| hours a | fural al E | d be | 15. Decedant's Edi | Yaar or Datas: | 16a De | cedant's Usual Occ | ounation | | | Wn | |
| 6 1 3 thin 72 | nd Mentel Hygiene. marked other than "natural", imatic event, the Medical Exa | Completed | (Specify only highast grad | fa complated) | (G. UG. | iva kind of work do a. DO NOT usa ret | na <i>during</i> most of wor ired) | king | DD. KIND OF BI | usinass/Industr | y |
| N With | r tha | E O | Elamentary/Sacondary (0-12) | College (1-4or 5+) | | | emaker | | | Home | |
| | vent, | Bec | 17. Fathar's Nama (First, Middla, Last) | | | | 18. Mother's Nen | na (First, Middla, M | la <i>iden Sum</i> am | na) | |
| y la | Ment arked atic e | To | | Phones Van | | | | azel Alma | | | |
| 2 sho | r Health and Mentel Hygiene. Item 27 is marked other than other traumatic event, the Me | | 19a. Informant's Name/Ralationship (T | ype. Pnint) Daughte | | | | | | | |
| bue l | m 27 | | Mrs. Susan S. Le | | | Robin I sposition (Nama of | Hood Road | | | | |
| Pages . | Department of relating and Mentel hygiene. Important: If item 27 is marked other than "I any Injury or other traumatic event, the Men once. | | 20a. Mathod of Disposition 1 X Burial 2 ☐ Cramation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Spacify, | Removal from Stata | cemetery, o | ramatory or othar p Hill Ceme | etery | | | de Gra | ace, MD |
| D ed | Important In Succession | | 21. Signatura of Funaral Sarvica License | San Survey St. | | Mitchell Havre | drass of Facility I-Smith Fu de Grace, | neral Ho MD 210 | me, P. 78-319 | Α. | |
| Phy | ysician | | 23a. Part1. Entar tha disaasa, or comp shock, or haart failure. List only o | lications that causad tha d na causa on eech lina | aath. Do not | anter tha moda of c | dying, such as cardiac | or raspiratory arra | st, | Inta | roximata rvsi Batween sel and Dentili |
| //\ | fledical | | Immediata Causa (Final disaasa or condition | C | Ten | Colo | ncer | | _ | 2 C A | n 12 |
| Ex | aminer | | rasulting in death) | a. Dua te | o (or as a cons | | VICE- | | - | COV | nor 43 |
| D | = | Iner | | | | a ! | | | | | |
| The lew requires that the death certificate be executed | physician and s the buriel-fransit | Examiner | Sequentially list conditions, if any, laading to immediate | Dua to | o (or as a cons | sequance of): | | | | | |
| | | | Cause. Entar Undarlying Causa (Disaasa or Injury | c | | | | | | | |
| icate | phys s the | Medical | that initieted avants rasulting in death) Lest | Dua to | (or as a cons | aquanca of): | | | | | |
| Certif | | | | d | | | | | | 1 | |
| de at | d for | icla | Part II. Other significant conditions co | ntribution to death but not | reculting in the | underwing source | sives in Red I | 22h Did tot | | | names of death 0 |
| The C | igned by the attendi be detached for use | Physiclan/ | rait ii. Other significant conditions co | ntributing to daath but not | n gnijiuser | a undariying causa | givan in Part I. | 1 □ Ye | | 3 Probably | cause of death? |
| s tha | pe de | ру Р | | | | | | | - 20110 | | |
| dainb | | | | | | | | 24a. Was an | | 24b. Ware a | utopsy findings a prior to |
| N N | 8 CA | Completed | | | | | | | | complet of death | tion of ceuse |
| | page | 50 | | | | | | 1□ Yas | 2000 | 1 ☐ Yas | 200No |
| clan: | certificate rector, pag | Be | 25. Was casa rafarred to madical axaminar? | | | | | th (Check only one |) | | |
| hysi | this c | 2 | ILI ias 2500 | | ☐ ER/Outpat | lant 3L DOA | | oma 5 🗆 Rasidar | | 1 1 27 | |
| Bull | After | io | 27. Mennar of Death 1 Delate 5 □ Pending | 28a. Data of Injury (Month, Day Year | 28b. Time Injur | y V | ljuryar Vork? □ Yas 2 □ No | 28d. Dascribe how | w Injury occur | red | |
| then | ctor: | llcal | 2 Accident Invastigation 3 Suicide 6 Could not be | 28a. Placa of Injury - A | I homa farm | | | 28f. Location (Str | aaf and Numb | er or Rural Rou | ita Number |
| 0 | Dire | Certification: | 4 Homicida datermined | building, etc. (Spe | ecify) | stract, ractory, ont | | City or Town, | | or or moral mor | , voil 507, |
| To the Hospital or Attending Physician: | 3 2 2 1 | edicai (| (Check only 2 Medical Exami | sician: To the best of my iner: On the basis of exem | nowledga, da Inetion end/or | eth occurred at tha invastigation, in m | tima, data and plece y opinion, deeth occu | , end dua to tha car rred at tha time, dat | use(s) and me te and pleca, | enner es stated. and dua to the | cause(s) |
| office of the | o the | Med | 29b. Signature and title of certifier | and marinigratished. | | | ansa number | | | d (Month, Dey, | |
| F | ક≓ઇ | | mto de | / . X | | m 5 | 229 | (1 | 1-1 | LV 19 | 50 |
| | | | 5-10 | | | 200 | 221 | Jan | yes | 1111 | . (|
| | _ | | 30. Nama and address of persons who ~ | mnlated cause of death /I | tem 23a) /Tun | e Print) | 1 | 1 10 | (4 4 | | |
| 11 | | | 30. Nama and address of person who or | omplated cause of death, (I | tam 23a) (Typ - (い / | e, Print) | ulp | mal Q | Il an | Moz | -14/5 |

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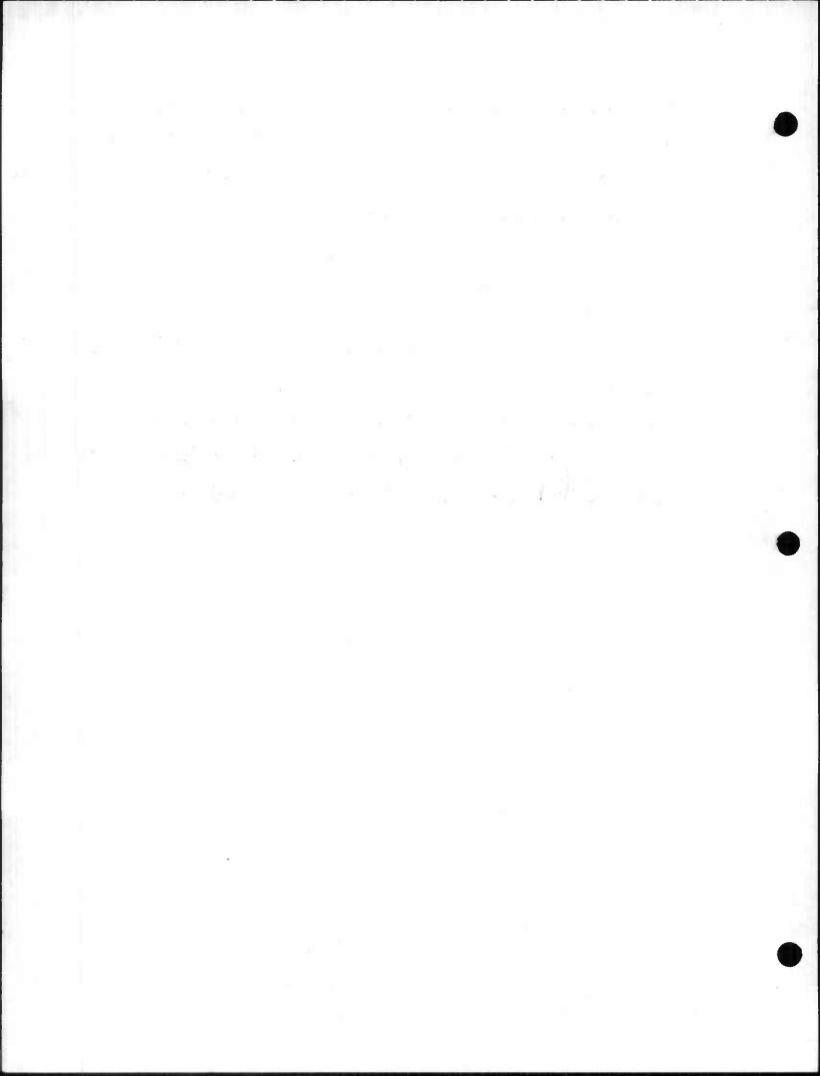
| | | | | | | | (| Certi | ficate of | Death | | | Reg. No | o | | - | - |
|---------------------|--|---------------------|---|----------------------------|--|--|-------------------------|-----------------------|---|---------------------------------------|-----------------------|-------------------------------------|----------------------------|------------------------------|----------------------------------|-----------|--|
| | Dharata | | 1. Decedent's Name (First | , Middle, La | st) | | | | | | | 2. Dete of D Month | | | Yeer | 3. Tir | ne of Death |
| | Physic /Medi | | Efraim | | Sto | ern | | | | | | | | 1997 | 1 001 | 9. | 11pm |
| | Exami | | 4e. Facility Name (If not in | stitution, giv | e street end numi | ber) | | | | 4b. City, To | wn, or Lo | ocailon of Dea | | | of Deeth | | |
| i | | | Suburban H | ospita | a1 | | | | | Bethe | | | N | iont | gomer | У | |
| | Funerai Director | | 5. Social Security Number 436–63–4069 Usual Residence of December 1 | | Sex 7 | . Age (In yrs. 79 | | | If Under 1 Yea Months Deys | | 24 Hrs. Min. | 8. Date of Bi (Month, D Dec 5 | irth ley. Year) 1917 | 7 | 9. Birthp Cour Hung | ntry) | tete or Foreign |
| | Maryland -f show | tor | 10a. Stete 10b. | County ntgome | ery | | ty, Town | | tion | | | | | | 1 | | de City Limiis Yes 2 □ No |
| | with the | i Direci | 10e. Street and Number | Ave ± | ±536 | | | | 10f. Zip Code 20852 | | | | 10g. Cit | tizen of V | What Cour | itry? | |
| Maryland 21215-0020 | a within 72 hours after death with the Maryland ijena. I than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at | by Funeral Director | 11. Maritel Staius 1 Never Married 2 | X Married | 12. Wes Deced Armed Ford 1 Yes 2 If Yes, Give Yeer or Dat | es? No | ı,S. | | s Decedeni of es, specify Cu Yes 2 No | | gin? (Sp , Puerto | ecify Yes or N Rican, etc.) | 0- | 14. Rac | e - Americ ck, While, Whit | elc | an, |
| ה ה | 72 hc | eted | 15. De (Specify only | ecedant's Ed | ducation de completed) | | 18a. E | Deceden | it's Usuai Occi | pation | t of work | ina | 16b. K | (ind of B | usiness/In | dustry | |
| 7 | C * 4 | Completed | Elementary/Secondary (| | College (1-4 | lor 5+) | | | d of work don NOT use retir | | OFWORK | n ry | | | | | |
| V | filed withi Hygiena. Ither than | Co | 12 | | | | Sal | es N | lanager | | | | | | ompan | y | |
| | of la b | Be | 17. Father's Nema (First, M Unobtainab | |) | | | | | | | e (First, Middle unobtai | | | 10) | | |
| 7 | should be nd Mental marked o | ဥ | | | | | ī | | | папп | ia (i | mobtal | nabi | .e, | | | |
| 3 | 0 0 0 | | 19a. Informant's Neme/Ra | letionship (| Type, Print) | | 19b. I | Mailing | Address (Stree | et end Numbe | er or Run | al Route Numi | ber, City o | or Town, | Stete, Zip | Code) | |
| 5 | 1 end Health em 27 | | Asaf Ashar— 20a. Method of Disposition 1 XBuriel 2 Crem 4 Donetion 5 D | netion 3 🗆 | Removal from St | ate | Plece of E cemetery, | Dispositi , cremet | ollins on (Neme of lory or other pi | ace) | | Rockvil Dete /26/97 | 20c. L | ocation - | City or To | | te |
| | permit. Pages Depertment of Important: If it any injury or o | | 21. Signature of Funeral | ervice Licer | 1664 | -Dani | e1 | 22. N | lame end Add | ress of Facilit | Edv | vard Sa | ige1 | | | Dire | ection |
| | _ | | 23a, Part1. Enter tha shock, or haart f | ana ar com | nlications that car | Simon | S Dono | Roc | kville | , MD 2 | 20852 | 2 or reeniratory | arract | | | Approx | dmate |
| | Physician | | shock, or haart f | tst only | one ceusa on aad | h lina. | | , ome | and mode or a | mig, oddir od | 0410100 | or reopiratory. | | | | intarva | Between and Death |
| | /Medicai | | Immediate Cause (Final | | Corobi | col Wo | a.m. 1 | - w 3 | | L 4 T |) d | | | | | 04.1 | |
| | Examiner | | disease or condition resulting in daath) | | a. Cerebi | | | | cciden | t in E | rair | istem | | | | 24 ł | ır. |
| | | <u>ē</u> | | | Anoxi | lc enc | enha | | | | | | | | 2 | 4 hr | |
| | nst ted | Examiner | | | b. ———— | | | | | | | | | | | -4 111 | • |
| | cate be executed physician and s the burial-fransit | Exa | Sequentially list conditions if any, leading to immedial cause. Enter Underlying Cause (Disease or injury | le l | Pognis | | or as a co | | nce of): | | | | | | | | |
| 3 | S G | | Cause (Disease or injury that initieted events | ~ < | Respi | | | | - | · · · · · · · · · · · · · · · · · · · | | | | | 12 | 4 hr | |
| 5000 | 문 문제 | /Medical | resulting in deeth) Last | l | d | Due to (c | raseco | nsaquer | nce of): | | | | | | | | |
| | death ce he attendi ed for use | Physician/ | Part II. Other algnificant c | onditions o | ontributing to dea | th but not res | ulting In t | the unde | erlying cause g | iven in Pert f. | | 23b. Dfd | tobacco | use co | ntributa to | the ca | use of death |
| | that the de ed by the detached | Phy | e/n Muocare | dini T | nfounti- | | | | | | | 1□ | Yes 2 | 2□ No | 3 Proi | bably | 416 Unknow |
| - | 2 5.2 | by | s/p Myocard | alal I | nrarctic | on | | | | | | | | | | | |
| 50000 | aw requir is been s 2 should | Completed | s/p CABG | (Secondalistics (S)) | - 10 | | | | | | | 24a. Wa peri | s an auto formed? | psy | av | ailabla p | psy findings prior to n of cause |
| | a 4 % | 0 | Atril fibri | llati | on | | | | | | | 10 | Yes 2 | No No | 10 |] Yas | 2□ No |
| | ician: Th certificate rector, pay | Be (| 25. Was casa referred to n | nedicai | | | | | | 26. Place | of Deetl | h (Check only | one) | | 1 | | |
| | Physician: this certific ral director. | 10 | 1 ☐ Yes 2 🕱 No | | Hospital: 1 XI Ing | oatient 2 | ER/Outp | patient | 3□ DOA O | ther: 4 🗆 Nu | rsing Ho | me 5 Res | idenca | 8 Oth | er (Specif | y) | |
| | After After a | ertification: | 2 Accident | Pending invastigation | 1 | Injury Dey Year) | 28b. Tir Inj | me of ury | 28c. Inj W M 1[| uryet ork?]Yes 2 □ I | | 28d. Dascribe | how Inju | гу оссиг | red | H | |
| DISSISSION OF | 무용하는 | Certific | 3 Sulcide 6 4 Homicide | Could not be determined | 289. Placa o | f Injury - At h , etc. <i>(Specit</i> | | n, sireet | , fectory, office | • | | 28f. Location City or To | (Street ar own, Stete | | er or Rure | I Route | Number, |
| | To the Hospital within 24 hours a To the Funeral E completely filled | edicai (| 29a. Certifier 1 Concept Check only one) | ertifying Phedical Exam | ysicien: To the be ninar: On the bes end menne | is of examina | wledge, o | deeih oo or invas | ccurred ei ihe tigation, in my | time, dete en opinion, dea | d plece, th occurr | end due to the ed et the time | ceuse(s | e) end <i>me</i> d place, | enner es si and due to | iated. | use(s) |
| | Within To th | ž | 29b. Signature end title of | outitier | | | 2 | | 29c. Licer | nse nu <i>m</i> ber | | | | | d (Month, | | |
| | 0 | | • | W | GAA | MAX | 1 | | D | 403 | (| 2 | 7 | 8 F | 25 | 10 | - |
| | 5 | | 30. Name and addrass of g | person who | M WY | of daath (Itar | / n 23a\ /T | vne Dri | | TUS | 7 - | ر | | J (', | 5 | 14 | / |
| | | | | | | , | , , | | , | | | | | | | | |
| | - 04 | | James Yan, | Year) | 119 ROCK | VIIIe | Pike | Ro | ckvill(| MD 2 | 0852 | - | - | - | _ | | |
| | Sta Registi | | 31. Date filed (Month Pay | 6281 | 997 | rurar's Sign | ridson | -Ran | delle | | | | | | | | |
| | | | | | 7 7/ | | | - | | | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene 97 27242

| | | | | | Ce | rtificate of | f Death | Re | eg. No. | , , | -/-7- |
|-------------|--|---------------|--|---|--|--|---|---|----------------------------------|-----------------------------|---|
| | U 20 G | | 1. Decedent's Name (First, Middle, Last) |) | | 0 | | 2. Date of Deat | h | | 3. Time of Death |
| | Physic /Medi | | Rebecca Rose R | Rocklin S | tepakof | | | August | 27, 1 | L 997 | 1:55am |
| | Exami | | 4a. Fecility Name (If not institution, giva | straet end number) | | | 4b. City, Town, or | Location of Deeth | 4c. County | | |
| | | , | 2201 Ross Road | l | | | Silver | | | gome | ery |
| | Funeral Director | | 133-01-0000 | | in yrs. lest birthday) 85 Yrs. | Months Dey | | 8. Date of Birth (Month, Dey, Apr. 27 | Year) , 1912 | 9. Birthpi Count Mass | aca <i>(State or Foreig</i> n try) achusett |
| | and * | | Usual Residence of Decedent 10a. State 10b. County | 1 | 0c. City, Town or Lo | ocation | | | | 1/ | Od. Inside City Limits |
| | Ba-f sho | Director | Maryland Montgo | | Silver | | | | | | 1 X Yas 2 No |
| | 23a or 2 | | 10e. Street and Number 2201 Ross Road | | | 10f. Zip Code 2 0 9 | | 10 | og. Citizan of V U S | | ry? |
| 020 | d within 72 hours after death with the Maryland jiene. I than "natural", or itema 23a or 28a-f show the Medical Examinat must be notilised at | by Funeral | 11. Marital Status 1 □ Navar Marriad 2 □ Married 3 ☑ Widowed 4 □ Divorced | 12. Was Decedent Eve Armad Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: | | Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🛣 No | f Hispanic Origin? (S iban, Mexican, Puar o <i>Specify:</i> | pecify Yes or No- to Rican, etc.) | | e - America ck, White, e | |
| 2-0 | 72 ho | ted | 15. Decedent's Educ (Specify only highest grade | cation | 16a. Dece | dent's Usuel Occi | upetion | de in a | 16b. Kind of Bu | usiness/Ind | ustry |
| 21215-0020 | within Jene. | Completed | Elementery/Secondary (0-12) | 2 ^{College (1-4or 5+)} | | unteer | e during most of wored) | rking | Civio | & F | Religious |
| | 高大寺兵 | BeC | 17. Fether's Name (First, Middle, Last) | | | | 18. Mother's Nar | ne (First, Middle, N | leiden Sumem | 10) | |
| lar | 0 0 0 | ToB | Joseph Rocklin | | | | Soph | ie Stro | ngin | | |
| Maryland | d 2 should th and Man 7 la market traumatic | - | 19e. Informant's Neme/Reletionship (Type | pe, Print) | 19b. Meili | ng Address (Stree | et end Number or Ri | ıral Route Number, | City or Town, | State, Zip | Code) |
| _ | CENL | | Richard J. Step | akof | 9416 | Ho1bro | ook Lane | Potoma | c, MD | 2085 | 54 |
| altimore, | | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donetion 5 ☐ Other (Special) | | Placa of Dispo cematery, cred King Da | metory or other pi | n. Gdns | 8/28/9F | 20c. Location - | City or Tov | vn, Stete |
| Ē | P 48 3 | | 21. Signature of Funeral Services Light | 6 | 2 | 2. Name end Add | ress of Facility | | | | , |
| m | Departi Departi Importi eny Inj | = | turk | 1001 | Ó I | ves-Pea | arson Fu | neral, H | omes | | |
| | | | 23a. Part1. Enter the disease, or compli | cations that caused the | The state of the s | rlingto | | 22201 | st. | | Approximate |
| | Physiclan | | shock, or heart failura. List only on | e cause on each line. | | | , , | | | | Intarval Between Onsat and Death |
| 1 | /Medical | | Immedials Couse (Finel | banely | 0.66 | on to | ated a | 2 do uno | na mi | 1 none | 2 . W. |
| 6 | Examiner | | diseese or condition resulting In deeth) a | 000119 | e to (or es a conse | Tem)(| 1 rec | ACCINO | 4 (1 | Moma | JUNG |
| | D 5 | ner | | Mass | 4 | escit | - C | | | | 3 mils |
| | eath certificate be executed attending physician and for use as the burial-transit | Examiner | Sequentially list conditions, | | e to (or as e consec | 1 | 13 | 0. | | | |
| , 0 | ertificate be execul ling physician and e as the burial-trar | | Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury) | Mass | ive | blees | rat | effee | 202 | 175 | INK. |
| 68760, | hysic the b | Medical | Ceuse (Diseasa or Injury thet Initiated events resulting In death) Last | Dua | to (or as a consec | uenca of): | 7 -1 | 16 | | | |
| × | entific ling p | Me | | | | | | | | 1 | |
| Bo | ath cuttend | | | | | | | | | i | |
| 0 | the a | Physician | Part II. Other eignificant conditions con | tributing to death but n | ot resulting in the u | nderlying cause g | iven in Part I. | 23b. Did tol | bacco use cor | tribute to | the cause of death? |
| Ω, | requires that the death een signed by the atter hould be datached for t | by Ph | Keypeste | n 810N | / | | | 1 □ Ye | 2 No | 3 Prob | ably 4 Unknown |
| Records, | v require been sig should b | Completed t | Escenti | al to | PALLO | ~ | | 24e. Was an | eutopsy ad? | ava | re autopsy findings ilable prior to |
| 3ec | Was as | npi | 0 000 | 0 1 | | 0 | . 0 . | | -/ | of d | npietion of causa leath? |
| <u></u> | cate h | ပိ | Subeliki | eal M | Took | ly Ro | 210180 | 7 1□ Ya | s 20 No | 10 | Yes 200 |
| Viital | ician: The certificate rector, pag | Be | 25. Was case referred to medical axeminer? | ennitel: | V | 1 | | ath (Check only one | 9) | | |
| | Phys this ral dir | To To | 1 Yes 2 No | ospitel: | 2 ER/Outpetier | IL SEL DON | | ome 5 Aesider | | |) |
| LC. | Aftar funer | ion | 1 Naturel 5 ☐ Pending | 28a. Dete of Injury (Month, Dey Yo | 28b. Time of Injury | W | uryet ork? ⊒Yes 2⊒No | 28d. Describe ho | w injury occurr | ed | |
| Division of | or Attending Physicism: after death. Director: After this certific i in by the funeral director, | ertification: | 2 Accident Investigation 3 Suicida 6 Could not be | 28e. Placa of Injury | - At home form str | | | 28f. Location (Str. | eet and Numb | er or Rural | Poute Number |
| 2 | tal or A rs after al Director | Certi | 4 Homicide determined | building, etc. (S | Specify) | oot, lactory, office | | City or Town, | Stete) | J. 67 1 10. 67 | alouio rumbor, |
| | To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completaly filled in by the funeral director, page | edicai | 29a. Certifier 1 Certifying Physic (Check only one) | iclan: To the best of mer: On the basis of exa and mannar stated | aminetion end/or in | occurred at the treatment occurred at the tr | time, dete end place opinion, death occu | , end due to the ce rred et the time, da | use(s) end ma te and plece, a | nner as sta and due to | ited. the cause(s) |
| | To the within 2 To the comple | Me | 29b. Signatura and title of certifiar | | | 29c. Licar | nse number | 29 | d. Dața signed | i (Month, E | Pey, Year) |
| | 5 | | D 7,0 | don a - | 1 Mi | 1. 0 | 1417 | 34 | R17- | 110 | 7 |
| | 1 | 1 | 30. Name and eddress of person who cor | mpleted cause of death | (Item 23e) (Type. | Print) | 101 | | 0/4 | 17 | 20819 |
| | | | IREME A.F | ELDM | AN | 5224 | - books | Hill K | Poad # | 1 Bes | Herda MZ |

DHMH 16 Rev 6/95

State Registrar



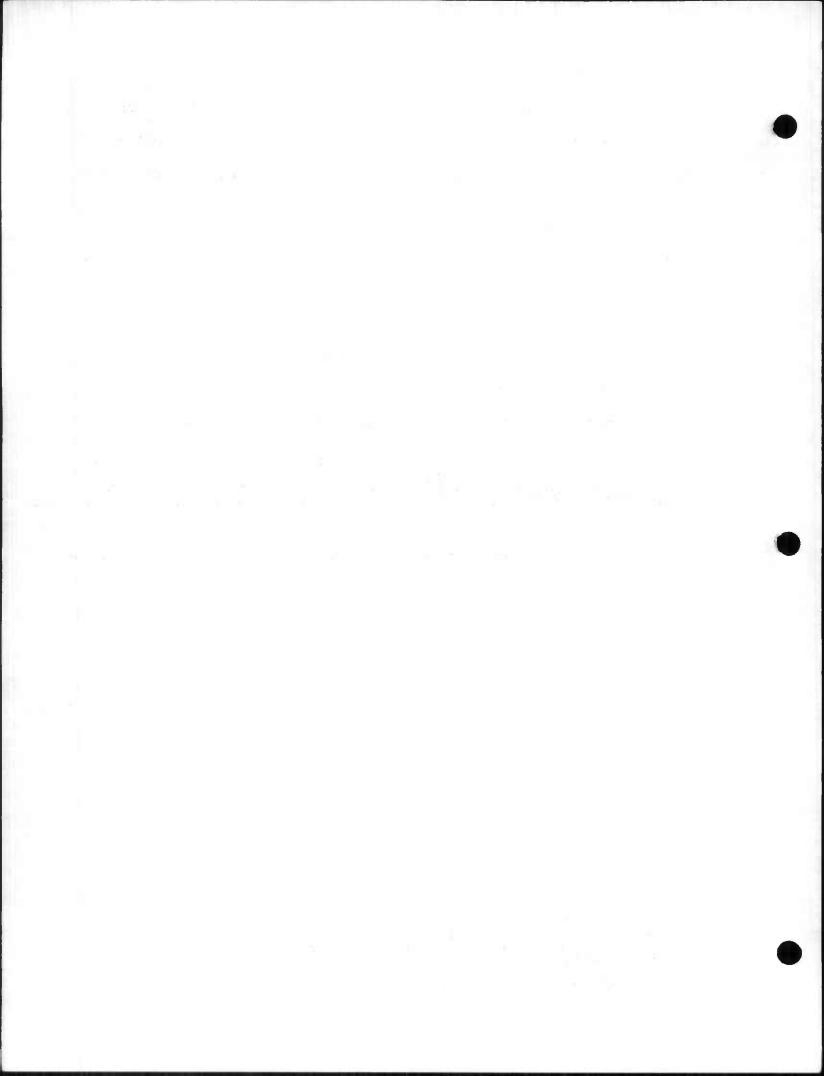
State of Maryland / Department of Health and Mental Hygiene

97 27243

| | | | | | | Cer | tificate | e of | Death | | F | leg. No. | | |
|--------------|--|----------------|--|--|-------------|-----------------------------------|---------------|----------|------------------|------------|---------------------------------|-------------------|--------------|---|
| | Dh | | 1. Decedent's Name (First, Middle, La | st) | | | | | | | 2. Date of Dea | th | Veer | 3. Time of Death |
| | Physic /Medi | | Ethel Kathryn | Sommer | | | | | | | Month August | : 18, 19 | 997 | 9:15 P.N |
| | Exami | | 4a. Facility Name (If not institution, giv | | | | | | 4b. City, Tow | n, or Loc | ation of Death | 4c. County | of Death | |
| | EAGIII. | | 9502 Hollins Cou | rt | | | | | Beth | esda | | Mont | tgome | rv |
| | Funeral | | 5. Social Security Number 6. S | | je (In yrs. | lest birthday) | If Under 1 | | | 4 Hrs. | B. Date of Birth (Month, Day | | 0 | - |
| | Director | | 460-30-8148 Usual Residence of Decedent | □M 2\\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | 72 | Yrs. | Months | Deys | Hours | Min. | (Month, Day March 2 | 3, 1925 | | lace (State or Foreign try) exas |
| | Mon Ha | | 10a. Stata 10b. County | | 10c. Cit | ty, Town or Loc | ation | | | | | | 10 | Od. Inside City Limits |
| | Man | ğ | Maryland Montgom | erv | | Betheso | la | | | | | | | 1 ☐ Yes 2 No |
| | 288 | Directo | 10e. Street and Number | | 1 | D0011000 | 10f. Zip (| Code | | | 1 | l0g. Citizan of V | What Count | trv? |
| | A S | 0 | OFO2 Nolling Co. | | | | | 081 | 7 | | | | | |
| | 7 2 m | era | 9502 Hollins Co | 12. Wes Decedent | Ever in U | .S. 13. W | | | | n? (Spec | ify Yes or No- | | ed Sta | |
| | /z nours after deeth with the Marylend natural", or ftams 23a or 28a-f show oldal Examiner must be notified at | by Funeral | 1 Never Married 2 Married 3 Widowed 4 Divorced | Armed Forces? 1 Yes 2 If Yes, Give Year or Dates: | | | | | Specify: | Puerto R | ify Yes or No- ican, etc.) | Specify Specify | ck, White, e | etc. |
| | n /2 nours *natural*, edical Exp | 8 | 15. Decedent's Ed | ducation | | 16a. Decede | ent's Usuel | Occu | pation | | | 16b. Kind of Bi | | |
| | E 2 | Completed | (Specify only highest gra | de completed) | | (Give k | ind of work | k done | during most o | of working | 7 | | | , |
| : | than the | E | Elementary/Secondary (0-12) | Collega (1-4or : | 0+) | 1 | Homema | ake | r | | | Own I | Tome | |
| ; | al Hygie other | | 17. Fathar's Name (First, Middle, Last) | | | | Tomeme | unc | 1 | s Name (| First, Middle, | Maiden Suman | | |
| : | e d o | Be C | Conde Auguste | Popoiat | | | | | Vati | h 201111 | Franch | Stear | | |
| | snould be and Mental I marked or umatic eva | P | 19a. informant's Name/Relationship (| | | 19h Mailine | Address i | /Strac | | | | r, City or Town, | | Code |
| 0 | traum | | Helmut Sommer / H | | | | | | | | | Marylan | | 0817 |
| | of Health Item 27 i | | 20e. Method of Disposition | usballu | 20h F | | | | | | | 20c. Location - | | |
| | nent of I | | 1 ☐ Burial 2 XCremation 3 ☐ | | - 0 | Place of Dispos cemetery, cram | atory or off | her pla | Aug. | 22, 1 | 1997 | | | |
| | tant | | 4 □ Donation 5 □ Other (Specify | | Mo | ntgomer | y Cre | ema | torium, | Inc | | Bethesd | a, Ma | ryland |
| | Demin. Peges Department of Important: If It any Injury or once. | | 21. Signature of Funeral Service Licer | 1500 | | D | | | ess of Facility | Fimer | al Home | Rockvill | o Inc | |
| | 70 E = 9 | | Darbara yo Mc/ | Mullenge | الاسان | | | | | | | | | 1 20850-280 |
| | | | 23a. Part1. Enter the disease, or com shock, or heart failura. List only | plications that ceused | the deat | | | | | | | | | Approximata |
| F | hysician | | Shoot, or heart tailura. List only | one causa on adon in | 110. | | | | | | | | | Interval Between Onset and Death |
| | /Medical | | Immediata Cause (Final disease or condition | Motaci | tatio | Breas | t Can | 003 | | | | | 1 | 2 Vanna |
| E | Examiner | | resulting in death) | a. Hetas | | | | Cel | | | | | 12 | 3 Years |
| | _0.5 | ě | | | Due to (c | or as a consaqu | ance or. | | | | | | 1 | |
| 7 | dansit | Examiner | | b | Due to /e | or as a consaqu | ionas ofti | | | | | | | |
| | n an | Exa | Sequentielly list conditions, if any, leading to immediate ceusa. Enter Underlying | | Dua to (c | r as a consaqu | ierice oi): | | | | | | I I | |
| 1 | ear remindere be executed effected by some and for use as the buriel-transit | | Cause (Disaase or Injury that initiated events | C | | | | | | | | | | |
| 2 | phy set | edical | resulting in death) Last | | Due to (o | r es e consequ | ence of): | | | | | | 1 | |
| 1 | nding se e | ₹. | | d | | | | | | | | | | |
| 44.5 | e etter | Physician | | | | | | | | | | | | |
| 1 | nature bearing the etter of deteched for u | ysi | Part II. Other significant conditions of | ontributing to death b | ut not res | uiting in the un | darlying ca | usa gi | ven in Part I. | | 23b. Did to | bacco use co | ntribute to | the cause of death? |
| 4 - 4 | ed by dete | | | | | | | | | | 1 🗆 Y | ee 2□ No | 3 Prob | ably W Unknow |
| | 2 2 2 | 1 by | | | | | | | | | 04- 11/ | | DAD WA | ro outopou findingo |
| - | been sign should be | Completed | | | | | | | | | 24a. Was a perform | med? | ava | re autopsy findings illable prior to applation of cause |
| - | 2 % | oldu | | | | | | | | | | | | leath? |
| É | | 00 | | | | | | | | | 1 □ Y | es 2 No | 1 🗆 | Yes 2 No |
| 1 | s certificate director, pa | Be (| 25. Was cese referred to medical | | | | | | 26. Place o | of Death | Check only or | 16) | | |
| Diam's later | is ce dire | To | examiner? 1 ☐ Yes 2 ② No | Hospital: 1 ☐ Inpatie | ent 2 | ER/Outpatient | 3□ DOA | A Ot | her: 4 Nurs | ing Home | e 5 🖾 Reside | ence 6 Oth | er (Specify |) |
| | | | 27. Manner of Death | 28e. Date of Inju | | 28b. Time of | 28 | c. Inju | | - | | ow Injury occur | | |
| alla. | th. : After e funer | it | 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Da | y rear) | Injury | М | | rk?]Yes 2∐No | 0 | | | | |
| 8 44 4 | of Attended the Director: After death. | fice | 3 ☐ Suicide 6 ☐ Could not be | 286. Place of Inj | ury - At ho | ome, farm, stre | et, factory, | office | | 28 | | | er or Rural | Route Number, |
| 1 | offer Director of in b | Certification: | 4 Homicide | building, ef | c. (Specif | y) | | | | | City or Town | n, State) | | |
| - Total | Meral Meral | 1 1 | 29a. Cartifier 1X Certifying Ph | yalcian: To the best | of my kno | wladge, death | occurred at | t the ti | me, date and | place an | d due to the o | ausa(s) and me | nner as ste | ated. |
| Lines. | Fur etely | edical | (Check only 2 Medical Exam | iner: On the basis of | axamina | tion and/or Inve | estigation, I | In my | opinion, death | occurred | at the time, d | ata and place, | and dua to | tha ceusa(s) |
| a ohe | within 24 hours effer deat To the Funeral Director: completely filled in by the | ₹ E | 29b. Signature and title of certifiar | | | | 29c. | Licen | se number | | 2 | 9d. Dete signe | d (Month, L | Dey, Yeer) |
| + | _ | | 14.1 | 2 / | / | 11 | 3 | | | | | | 3 10/2 | |
| < | - | | augn 1 | mar | u | - 2 | 1 | | D37236 | | | August | 19, | 1997 |
| | | | 30. Name and address of person who | | | | | | | | | | | |
| | | | Carolyn 🔣 Hendr | icks, M.D. | 97 | 07 Med: | ical (| Cen | ter Dr | ive, | Rockvi | ille, M | 20 | 850 |

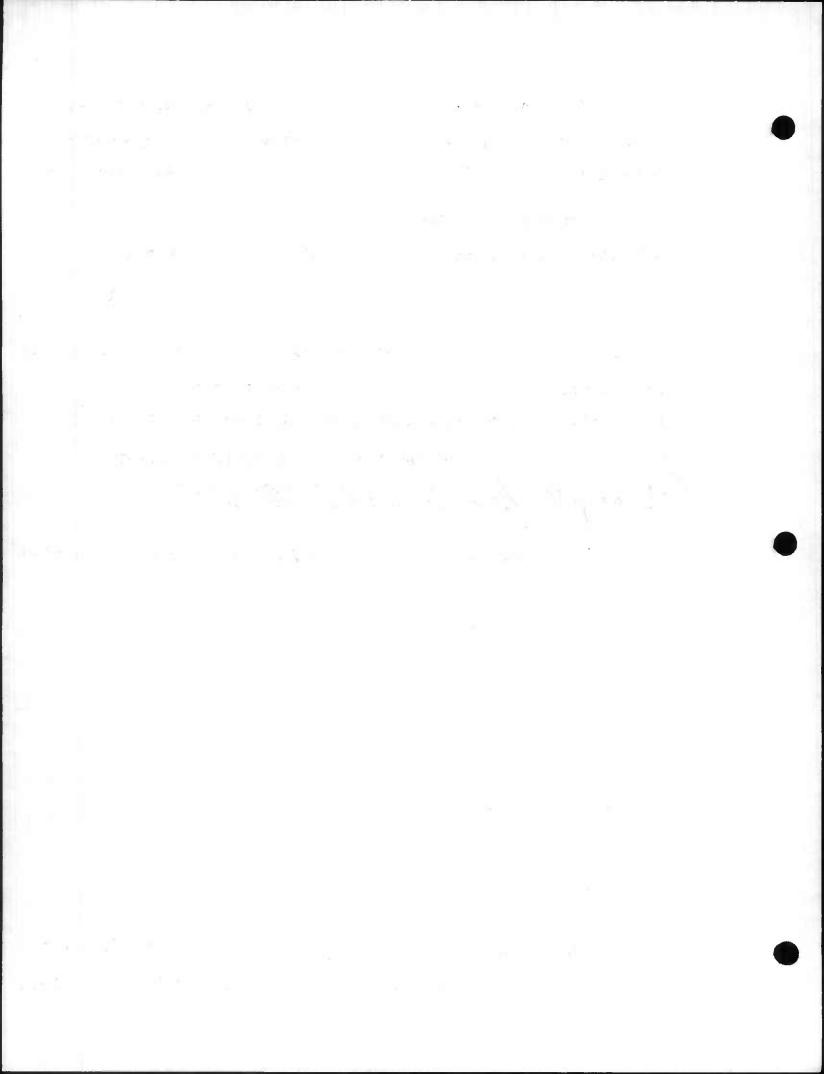
DHMH 16 Rev 6/95

State Registrar



State of Maryland / Department of Health and Mental Hygiene 97 27244

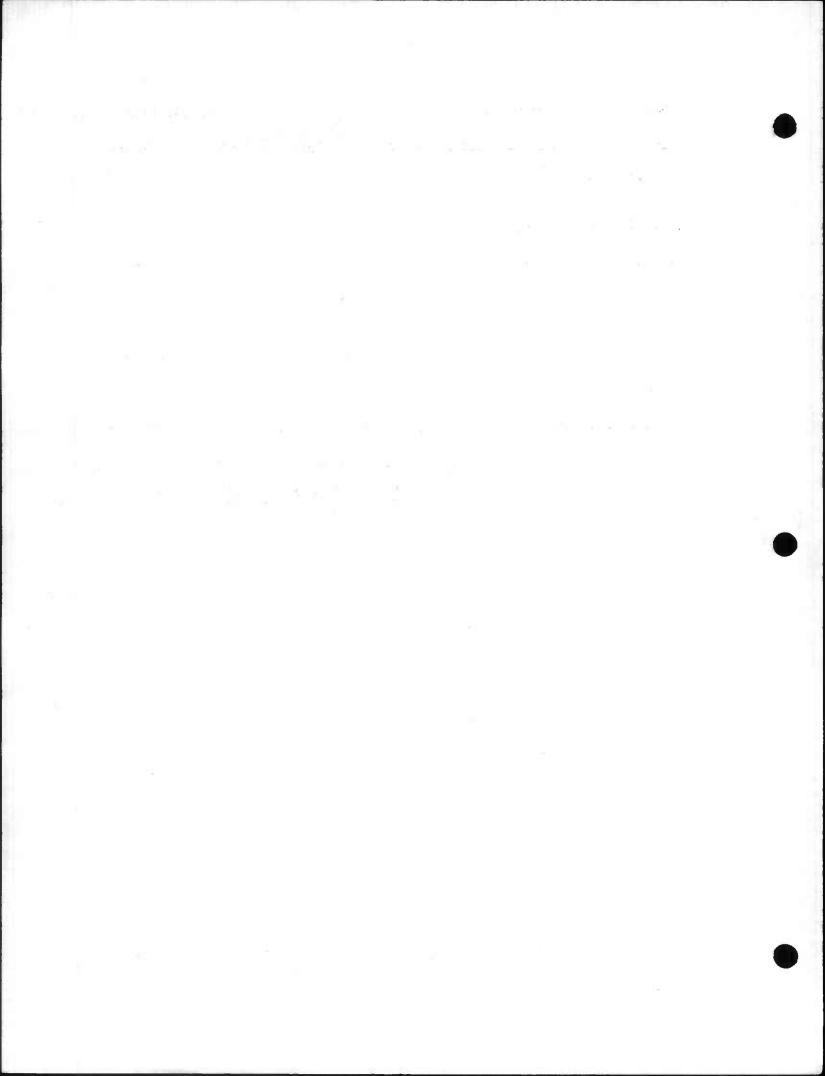
| | | | | | Cei | rtificate of | Death | F | Reg. No. | | |
|--------------------|---|----------------|--|--|--|--|---|---|--------------------------------|---|---|
| | Discontinu | | 1. Decedent's Name (First, Middle, L | ast) | | | | 2. Dete of Dee | oth | | 3. Time of Death |
| | Physic /Medi | | BETTY | A. SM | ITH | | 2 | August | 25, 1 | 997 | 1439 |
| | Exami | | 4a. Fecility Name (If not institution, g | ive street and number) | | | 4b. City, Town, or Lo | cation of Deeth | 4c. County | of Death | |
| | | | Montgomery Ge | eneral Hos | pital | | Olney | | MON | TGOME | RY |
| , | Funeral Director | | 214-42-6691 | Sex 7. Age (1 M 2 | In yrs. last birthday) Yrs. | If Under 1 Year Months Days | | 8. Dete of Birth (Month, Day Feb. 4 | ,1942 | 9. Birthplac Country, Wash | e (State or Foreign |
| - | how | | Usual Residence of Decedent 10a. State 10b. County | 1 | 0c. City, Town or Lo | ocation | | | | 10d. | . Inside City Limits |
| Mo | S - S | Director | MD Montgo | mery | Boyds | | | | | | X ☐Yes 2☐No |
| de se | 2 2 | Dire | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen of \ | | ? |
| 40 | 238 | rai | 23310 Shiloh | Church Ro | | | 841 | | U.S. | Α. | |
| | Examiner must be notified at | by Funeral | 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorcad | 12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🎇 No | Hispanic Origin? (Spe ean, Mexican, Puerto I Specify: | cify Yes or No- Rican, etc.) | Blac | a - American ck, White, etc :: Blac | |
| 4ihin 70 hausa of | naturai'. | Completed | 15. Decedent's l (Specify only highest g | Education | 16a. Dece | dent's Usual Occup | pation during most of workii | 200 | 16b. Kind of Bi | usiness/Indus | itry |
| 7 | f Health and Mental Hygiens feen 27 is marked other than "natu other traumatic event, tra Medical | npie | Elementery/Secondery (0-12) | College (1-4or 5+) | life. | DO NOT use retire | nd) | | | | |
| 4 3 | marked other than marked other than marked other than | Cor | 12th | | Bu | ıs Opera | | | | | Schools |
| and yield a | d oth | Be | 17. Father's Name (First, Middle, Las | t) | | | 18. Mother's Name | | | ie) | |
| o do | Men | To | Aubrey Bruce | _ | | | | E. Smi | | | |
| 2 0 | is me | | 19e. Informant's Name/Relationship Kim L. Smith- | | 19b. Mailir | ng Address (Street | and Number or Rura Shiloh | Ch D | r, City or Town, | State, Zip 2 | g841 |
| - 1 | Health em 27 rther tr | | 20e. Method of Disposition | Edwards (| 20b. Place of Dispo | |) PHITOH | Date Date | 20c. Location - | | |
| Daiminoic, | y or If | | 1 ☑ Buriel 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec | ify) | MD Nat | 1 Mem. | Park 8, | /30/97 | | el, M | |
| 1 6 | Departme importan eny injur | | 21 Signature of Funeral Service Lice | D. Ann | A S | Name end Address NOWDEN OCKVILI | FUNERAL | HOME, | P.A. | | |
| | _ | | 23a. Part1. Enter the disease, or conshock, or heart feilur. List on | mplications that caused th | e death. Do not ent | ter the mode of dyl | ing, such es cardiac o | r respiratory er | rest, | A | pproximate iterval Between |
| OA GOT GOT, | physician end s the bunal-transit | ai Examiner | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause, (Disease or Injury | b. Ray | e to (or as a consection to (or as a consection as a consection) | quence of): | my. | | | 1 | |
| Contilion of | oding se as | n/Medicai | that initiated events resulting in death) Lest | d | e to (or es e conseq | uence of): | | | | | |
|) ह | e atte | icla | Part II. Other eignificant conditions | contributing to death but i | not resulting in the u | nderlying cause di | ven in Part I | 23b. Did t | obacco una co | ntribute to th | ne ceuse of death? |
| af the | ed by the | Physician | | ooning to dout out | Tot rooding in the a | ridoriying oddoo gi | von arr arr. | 1 🗆 1 | / | | oly 4 🗆 Unknowr |
| requires that | 5 8 | by | | - | | | | | | Toth Man | a da a sulfia dia a s |
| 5 | peen s | etec | | | | | | | an autopsy med? | availa | autopsy findings able prior to eletion of cause |
| to low requires to | S C/ | Completed | | | | | | | | of dea | ath? |
| . F | pa | | | | | | | 1 🗆 Y | es 2 No | 1 🗆 Y | res 2□ No |
| Physician. Th | s certificate director, pag | Be | 25. Was case referred to medical examiner? | Hospital: | | _ 01 | 26. Plece of Deeth | | | | |
| b dd | | : To | 1 ☐ Yes 2 ☐ No 27. Manner of Deeth | 1 La inpatient | | " SEL DON | 4 LI Harsing Hor | | enca 6 □Oth ow injury occur | | |
| ding | leath. Ior: After the fune | tion | 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigati | 28a. Dete of Injury (Month, Day Y | (ear) Injury | Wo | ork?]Yes 2□No | | ,, | | |
| or Attending | ireci ireci n by | Certification: | 3 Suicide 6 Could not determine | De Diago of Joine | - At home, farm, str (Specify) | | - | 28f. Location (S City or Tow | Street and Numb m, State) | per or Rural R | loute Number, |
| Hoenite | within 24 hours effer To the Funeral Dir completely filled in | edicai C | | hysician: To the best of r miner: On the basis of ex and manner state | caminetion end/or in | | | | | | |
| of the | vithin o the | Me | 29b. Signature and title of cartifier | | | 29c. Licen | se nu <i>m</i> ber | | 29d. Date signe | d (Month, Da | y, Year) |
| | (1) | | Marfor . S. | Man | | (1.1. | 7-7-7 | | August | 25, | 1997 |
| | 60 | | 30. Name and eddress of person who max of the s. 31. Date filed (Month, Day, Yeer) AUG 2 8 | completed cause of ties | th (Item 23a) (Type | Print) | - 1 / 7 | | | • | |
| | | | MAXUEM S. | manne | 7-211-1 | -KESEZ | ARCH BL | UD - C | GA ITHER | essur 4 | 177 |
| Ī | Sta | te | 31. Date filed (Month, Day, Yeer) | 32. Registrar | Signature | 0 4 | | ע | | | 7017 |
| | Registr | ar | AUG2 8 | 1991 July | an Davidson-P | andelle | | | | | |



State of Maryland / Department of Health and Mental Hygiene

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|---|---|-----|---|----|------|
| | 9 | 7 | 2 | 1. | lug. |
| | 6 | - / | 6 | 14 | J |
| | - | | - | | _ |

| | | | | | | Cer | tificate o | f Death | | R | eg. No. | | | |
|------------|--|----------------|--|-----------------------------------|-------------------|----------------|-------------------------------------|--------------------------------|---------------------|----------------------------------|---------------------------|--------------|------------------------|----------------------|
| | | 37 | 1. Decedent's Nama (First, Middla, L | ast) | | | | _ | | 2. Dafa of Daa | th | | 3. Tim | a of Death |
| | Physici | | George Francis | Skarnulis | | | | | | Month August | 2/ ₁ 100 | Yaar O 7 | 12 | :15 PM |
| | /Medi Examir | | 4a. Facility Nama (If not Institution, g | | | | | 4b. City, To | own, or Lo | cation of Death | 4c. County | | 1_12 | : 15 PM |
| | LAGIIII | ICI | Springbrook Adv | antict Nurc | ing Co | ntor | | C:1:00 | × Cn. | rina | Mon | + | 2011 | |
| - | Francis | | | Sax 7. Ad | a (In vrs. last b | irthday) | If Undar 1 Yas | Silve ar If Undar | 24 Hrs. | | | g Birthr | _ | ata or Foreign |
| | Funeral Director | | 478-12-8276 | 1⊠ M 2□ F | 74 | Yrs. | Months Day | s Hours | Min. | (Month, Day | Year) | Cour | itry) | ta or r oreign |
| | Difector | | Usual Rasidance of Decedant | | / 4 | | | | | Aug.15, | 1923 | Iowa | | |
| | B 18 18 | | 10a. Stata 10b. County | | 10c. City, To | wn or Loc | cation | | | | | 1 | 0d. Insid | a City Limits |
| | day day | 5 | | | | | | | | | | | 10 | Yas 2 No |
| | 2 48 | Director | Maryland Prince (| George's | Ade | lphi | 100 75- 0-1- | | | | 0. 0. | 117 | | 25 |
| | with the Marylar te or 28a-f show t.be notified at | 눕 | Toe. Street and Number | | | | 10f. Zip Code | | | , | Og. Citizen of | what Cour | itry / | |
| | £ 2 H | Ta . | 2402 Lackawanna | Street | | | 20 | 0783 | | | U.S. | Α | | |
| | er death with the Marylar flems 23e or 28e-f show ner must be notified at | Funeral | 11. Marifai Sfafus | 12. Was Decedant Armed Forcas? | Evar in U,S. | 13. V | Vas Decedant of Yas, specify Cu | f Hispanic Or Jban, Maxical | igin? (Spen, Puarto | ecify Yas or No- Rican, afc.) | | ce - Amaric | | ١, |
| 0 | nours after ural, or its at Examine | | 1 ☐ Nevar Married 2 ☑ Married | H Vac Giva | | | ☐Yas 2♥N | | | , | Specif | | | |
| 02 | Eric Par | by | 3 ☐ Widowed 4 ☐ Divorced | Yaar or Datas: | WW II | ' | المرك وما الما | о эреспу. | • | | Specif | | nite | |
| 21215-0020 | 72 h | Completed | 15. Decedant's I | Education | | | ant's Usual Occ | | at all wants | in a | 16b. Kind of B | usiness/in | dustry | |
| 2 | within 7 then 'r be Med | pie | (Specify only highast g Eiementary/Secondery (0-12) | Coilega (1-4or 5 | 141 | lifa. D | kind of work don OO NOT usa reti | red) | st of worki | ng | | | | |
| 2 | 2844 | 0 | 12 | oonoga (1 vor e | | parti | ment Man | nager | | F | ерсо Е | lectr | ic | |
| P | and the first | Bec | 17. Fathar's Nama (First, Middla, Las | st) | | | | | ar's Nema | (First, Middle, | | | | |
| a | dental Aental rhed o | To B | Martin Skarnu | lic | | | | C | ather | rina (| Cesna | | | |
| 7 | 2 should be and Menta is marked sumatic er | H | 19e, Informant's Name/Ralationship | | 19 | h Mallin | n Addrage (Stre | | | al Route Number | | State 7in | Codel | |
| Maryland | nd 2 i | | | | | | | | | | | | | |
| | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | | Jean E. Skarnul: | 1.5 | 20h Place | of Dispos | Lackawas sition (Nama of | nna St | reet | Adelph | 11. Mary 20c. Location | land | 2078 | 3 |
| ō | Pages vent of s rut: If its rry or o | | 1 ☑ Burial 2 ☐ Cramation 3 | Ramoval from Stata | cemat | ary, crem | natory or other p | vlace) | i | Data | ZOC. LOCATION | - City Of To | wii, State | |
| 븚 | E de tra | | 4 ☐ Donation 5 ☐ Othar (Spec | sity) | Gate c | of He | eaven Ce | metery | 7 8 | 1/28/97 | Silver | Spri | ng, M | aryland |
| Baltimore, | permit. Pag Department Important: any injury o | | 21. Signature of Funaral Service Lice | ensaa | | | Nama and Add | | | | | _ | | |
| 5 | 20229 | | 1 9 Villian | Z 15 y | X | Fra | ancis J | . Coll | ins l | Funeral .,W.,Sil | Home, | inc. | MD 3 | 0001 |
| | | | 23a. Part1. Enfar the disease, or conshock, or heart fallure. List only | mplications that caused | tha daath. Do | not anta | or tha moda of d | ving, such as | Cardiac o | or raspiratory arr | asi. | ring, | Approxi | |
| | Dhusisian | | shock, or haart fallura. List onl | y ona ceusa on aach lii | na. | | | , | | | 500 | 1 | Intarval | Batween and Death |
| | Physician /Medical | | fmmediete Causa (Final | 5 | | | | | | | | | | |
| | Examiner | | disaasa or condition rasulting in death) | a. 11e | umo | 470 | 9. | | | | | | 3 | days. |
| | | <u></u> | | - | Dua to (or as a | a consequ | uance of): | | NI | | | | | |
| | p # | Examiner | | b. + 0 | npair | ed | Gag uence of): | Ko | 7 /e | X | | <u> </u> | < , | yr. |
| | and I-trar | хап | Sequentially list conditions, if any, leading to immadiate cause. Entar Undarlying | | | | | | | | | | | / |
| 68760, | cian cian | | cause. Entar Undarlying Cause (Disaasa or Injury | Pq. | cins | 01 | ism | | | | | | 2 0 | 0 y-5. |
| 87 | artificate be executed ing physician and e as the burlal-transit | Medical | that initiated evants rasulting in death) Last | ** | Dua to (or as a | | | | | | | | | |
| 9 X | ling p | Me | | | | | | | | | | | | |
| Bo | eath ce ettendi for use | and | | d | | | | | | | | | | |
| | that the death certificate be executed ed by the ettending physician and detached for use as the burtal-transit | Physician/ | Part II. Other significant conditions | contributing to death be | ut not rasulting | In the un | darlying ceusa | givan In Part | 1. | 23b. Did to | bacco use co | ontribute to | the cau | se of death? |
| Ö | t the de by the tached | hy | | , | _ | | | | | 1 D Y | es 2 No | 3 □ Proi | bably | 4 D Unknown |
| σ, | the de | by P | Milal Fibi | rillatio | 1, | 01 | 9 857 1 | ve_ | | | | | , | |
| Records, | requires i | | Atrial Frb. Heart Fail | / | / | , (| V | | | 24a. Was a | n autopsy | 24b. W | ara autor | sy findings |
| Ö | 77 (0) | Completed | Heart tail | u-e, V4 | ciani | + (| 022. | | | perfor | med? | CO | allabie pr mpietion | or to of cause |
| š | 2 0 N | du | | | 1 | | | | | | | of | death? | |
| | E ag | Ö | | | | | | | | 1 □ Y | es 2 No | 10 | Yes | 2□ No |
| Vital | ysician: The s certificate director, pag | Be | 25. Was cesa rafarrad to medical axaminar? | | | | | 28. Place | e of Deeth | (Check only or | 10) | | | |
| of | G 60 % | ည | 1 Yas 2 No | Hospital: 1 ☐ Inpatie | nf 2 ER/C | Outpatient | 1 3□ DOA | Other: 4 N | ursing Ho | ma 5 Rasido | ence 8 Ott | nar (Specif | y) | |
| 0 | g Ph ler th | | 27. Mannar of Death | 26a. Dete of Inju (Month, Da) | ry 28b | Tima of Injury | 28c. In W | jury at | | 28d. Describe h | ow Injury occur | rred | | |
| 0 | Ath. :: After e funer | atio | 1 ☑Natural 5 ☐ Panding 2 ☐ Accidant Investigeti | | , 1 out) | прогу | | Yas 2 | No | | | | | |
| Division | or Attending after death. Director: After in by the fune | Certification: | 3 Sulcida 6 Could not datamine | d 259. Place of inju | ury - At homa, | farm, stre | et, factory, offic | 28 | | 28f. Location (S | treet and Numi | ber or Rura | I Routa I | Vumber, |
| ă | after Direct Dir | en | 4 Homicida | building, at | c. (Specify) | | | | | City or Town | n, Stata) | | | |
| | To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the fune | | 29a. Cartifiar 1 Certifying P | hysician: To the bast o | of my knowledg | a death | occurred at the | time data as | nd place | and due to the o | auea/e\ and m | 400ar ee e | teted | |
| | Hos Fun stely | edical | | minar: On the besis of | axamination a | nd/or Inv | astigation, in my | opinion, des | oth occurr | ed at tha fima, d | ata and place, | and dua fo | tha cau | sa(s) |
| | To the within To the | Me M | 29b. Signature and Mile of certifier | and mannar su | 1 | | 20c Lice | nsa number | | | Od Dete elane | ad (Month | Day Var | e) |
| | | - | 1 | 1 1.7 | 4 | | | | | 2 | 9d. Dafa signe | / (WOTH) | way, rea | "/ |
| | PA | | sut | FU | IND | - | 1 | 3/0 | 100 | | 8/2 | 6/9; | 2 | |
| | • | | 30. Nama and address of person who | completed square of d | eath (Jem 23a |) (Type, F | Print) 750 | 00 6- | -een | way (| atr. I |)r. It | 430 | 2 |
| | | | Stuart | urken | i7 8, | 17.0 | . 6- | eent | elt | MD. | 2077 | Ø. | | |
| | Sta | ite | 31. Data filed (Month, At 152) | 1007 32. Ragis | ar's Signatura | - | | | | | | | | |



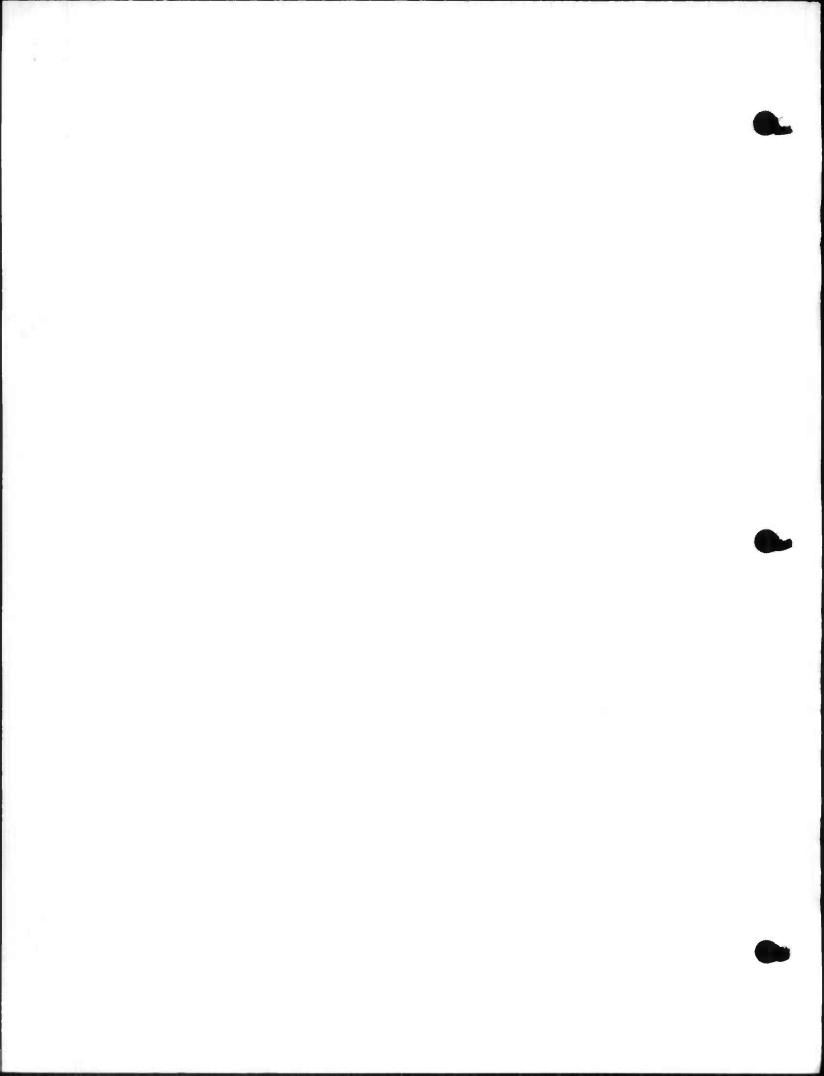
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27246

| | | | | | | Cer | tificat | e of | Death | | leg. No. | | |
|-------------|---|----------------|---|---|-------------------------------------|--------------------------------|--------------------|----------------------|-----------------------------|---|-----------------------------|---------------------------|--|
| | Physic | ian | Decedent's Name (First, Middle, Last | | | | | | | 2. Date of Dea Month | Day | Year | 3. Time of Death |
| 4 | /Medi | | Abraham | Silve | ersin | 1 | | | | August | 26, 19 | 97 | 11:35 Pm |
| | Exami | | 4a. Facility Neme (If not Institution, give | street and number; | | | | | 4b. City, Town, o | Location of Death | 4c. County | of Death | |
| | | | 14400 Home Cre | st Rd. | | | | | Silver | Spring | Mont | gomer | У |
| | Funerai Director | | 160-10-38/2 | X 7. Ag JM 2□F | ge (In yrs. la 84 | rst birthday) Yrs. | If Under Months | | If Under 24 Hr Hours Mir | | Year) , 1912 | 9. Birthpi Count PA | lece (State or Foreign try) |
| | death with the Maryland ms 23a or 28a-1 show | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City | Town or Loc | cation | | | | | 10 | 0d. Inside City Limits |
| | the Maryla 28a-1 show | Director | MD. MONTGO | MERY | | SILVE | ER S | PRI | NG | | | | 12 Yes 2 No |
| | or 28 | ire | 10e. Street and Number | | | | 10f. Zip | Code | | | log. Citizen of | What Count | try? |
| | 23a or | ai | 14400 HOME | CREST I | RD. | | | 20 | 906 | | U | .S.A | |
| | | Funeral | 11. Marital Status | 12. Was Decedent Armed Forces | | 3. 13. W | Vas Deced | dent of I | lispanic Origin? (| Specify Yes or No- irto Rican, etc.) | | e - America | an Indian, |
| 5-0020 | a 9 E | by Fu | 1 Never Married 2 Married 3 Widowed 4 Divorced | 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: | No | 1 | | | Specify: | ito rican, etc.) | Specif | ck, White, e | HITE |
| 0 | 72 hours "naturel", | P | 15. Decedent's Edu | cation | | 16a. Deced | ent's Usua | al Occup | petion during most of w | | 16b. Kind of B | usiness/ind | lustry |
| 215 | e 1 20 | Completed by | (Specify only highest grad | · · · · · · · · · · · · · · · · · · · | - | (Give I life. D | kind of wor | rk done se retire | during most of wid) | orking | | | |
| 2121 | within iena. than | E | Elementary/Secondary (0-12) | College (1-4or | 5+) | 5 | SALE | SMA | N | | RET | AIL S | SALES |
| | il Hygid other | 0 | 17. Father's Neme (First, Middle, Last) | | | | | | 18. Mother's Na | ame (First, Middle, | Maiden Sumar | ne) | |
| Maryland | Mental Mental arked o | To Be | LOUIS | SILVE | RSTN | | | | | UNKNO | NWN | | |
| Z | should by nd Menta marked umatic ev | Ĕ | 19a. Informant's Name/Relationship (T) | | ND III | 19h Mailin | n Address | /Street | and Number or F | Rural Route Numbe | | State Zin | Code) |
| Ma | d 2 sho th and 7 is me treum | | | | | | | | | | | | |
| o T | 1 an Heali Im 2 | | LOUIS SILVERS 20a. Method of Disposition | SIN/SON | 20h Pla | 19// aca of Dispos | | | ADAMS S | Dete ARI | 20c. Location | | |
| 0 | H H | | 1 ☐ Burial 2X Cremation 3 ☐ F | | | metery, crem | atory or o | ther pla | ce) | | | | |
| ti T | tmen tant: jury | | 4 ☐ Donation 5 ☐ Other (Specify) | | CHA | MBERS | CR | EMA | TORY | 8/28/97 | RIV | ERDAI | LE, MD. |
| Baltimore, | permit. Pages 1 and 2 Department of Health a Important: If Item 27 is eny Injury or other tre DDCs. | | 21. Signature of Funeral Service Licens | n heu de | Zunna | | | | ess of Facility | SILVE AL HOMES | ER SPR | ING, | |
| | _ | | 23a. Part1. Enter the disease, or compleshock, or heart lailure. List only of | lcations that cause | | | | | | | | | 20910 Approximate |
| | Physician | | shock, or heart failure. List only o | ne cause <i>on</i> each li | ne. | | | , | | | | | Approximate Interval Between Onset end Deeth |
| | /Medical | Ш | Immediete Ceuse (Finai | | 6 | ٠, ۲, | | | 1 0- | | / | | Montles |
| 1 | Examiner | П | disease or condition resulting in death) | A | C 3/ | phi | ag | 20 | 1 Ca | ncer | | | Monius |
| | | <u></u> | | | Due to (or | as å consequ | uenca 🐗: | | | | | | |
| | pei tist | Examiner | | D. ————— | | | | | | | | | |
| | requires that the death certificate be assecuted been signed by the attending physician and chould be detached for use as the bunal-transit | хаг | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events | | Due to (or | es a consequ | uence oi): | | | | | | |
| 60, | cian cian buria | <u>=</u> | cause. Enter Underlying Cause (Disease or Injury | 0 | | | | | | | | | |
| 68760, | sate the | edical | that initiated events resulting in death) Last | | Due to (or | es e consequ | ienca of): | | | | | | |
| | ling pa as | | | 4 | | | | | | | | | |
| Вох | attendin for usa | an | | | | | | | | | | İ | |
| | that the death cer ed by the attendin deteched for use | Physician/N | Part II. Other significant conditions cor | ntributing to death b | ut not resul | ting In the un | derlying c | ause giv | ven in Part I. | 23b. Did to | obacco use co | ntribute to | the cause of death? |
| P.0 | by t | Phy | | | | | | | | 1 🗆 Y | 00 2 No | 3 Prob | ably 4 Unknown |
| | igned l | þ | | | | - | _ | | | | | | |
| Records, | quire en si buld | | | | | | | | | 24a. Was a | | 24b. We | re autopsy findings ilable prior to |
| S | | Completed | | | | | | | | polito | | con | mpletion of cause death? |
| | 0 - 0 | E C | | | | | | | | 1 D Y | es 2 PNo | 10 | Yes 2□ No |
| a | ician: The certificate rector, pag | Ö | 25. Was case referred to medical | | | | | | 00 Di / D | | | , , | 165 2 140 |
| of Vital | ysician: s certific director, | 00 | examiner? | lospital: | | | -5 | Oth | ior: | eath (Check only or | | | |
| o | Physician: this certific ral director, | -: To | 1 ☐ Yes 2 ☑ No | 1 ☐ Inpation | | R/Outpetient 28b. Time of | | A | 4 Nursing | Home 5 P Resid | | | " |
| L C | After fune | lon | 1 Paturel 5 ☐ Pending | (Month, Da | y Year) | Injury | м | 8c. Injui Wor | k? Yes 2 □ No | 200. 2000/100 11 | ow injury coods | 100 | |
| Division | I or Attending I after death. Director: After I in by the funer | Certification: | 2 Accident investigation 3 Suicide 6 Could not be | On Division (1) | A. N. | U | | | 168 2 140 | OPf Location (C | annat and them | in an Orman | (Paula Number |
| <u>></u> | or Al | ŧ | 4 ☐ Homicide determined | 28e. Place of Inj building, et | ury - At non c. <i>(Specify)</i> | | et, factory | , office | | 28f. Location (S City or Tow | n, State) | per or Hurai | Houte Number, |
| | ral D | | | | | | | | | | | | |
| | 4 hor | edicai | 29a. Certifier 1 Certifying Physical Check only 2 Medical Examination | nician: To the best ner: On the basis of | ol my know I examinatio | ledge, death on and/or inve | occurred a | at the tir | me, date and place | e, and due to the coursed at the time. | ause(s) and make and placa. | anner as sta | ated. the cause(s) |
| | To the Hospital or Attending Phi within 24 hours aftar death. To the Funeral Director: After thi completely filled in by the funeral | | one) | and manner st | ated. | | | | | | | | |
| | 5 1 × 5 0 | - | 29b. Signature and title of certifier | 9 71 | 11.1 | | 290 | Licens | e number | 123 | Date signe | d (Month, L | Day, Year) |
| | 9 | | Ball AG | KULG | W | | | U 3 | 1720 | | nugo | >12 | -1,1997 |
| | ` | | 39. Name and address of person who con the control of the control | empleted cause of o | leath (Item | 23a) (Type A | Srint)- | 6 | Philips | Sy#Siz | du | 24 | ded 20832 |
| | Cto | te | 31. Date liled (Month, Day, Year) | 32. Regist | ar's Signatu | iie _ | | | | | | | |

J Fig. 1 with a section of the graph of the first factor of the contract of the att follows to the second second second second

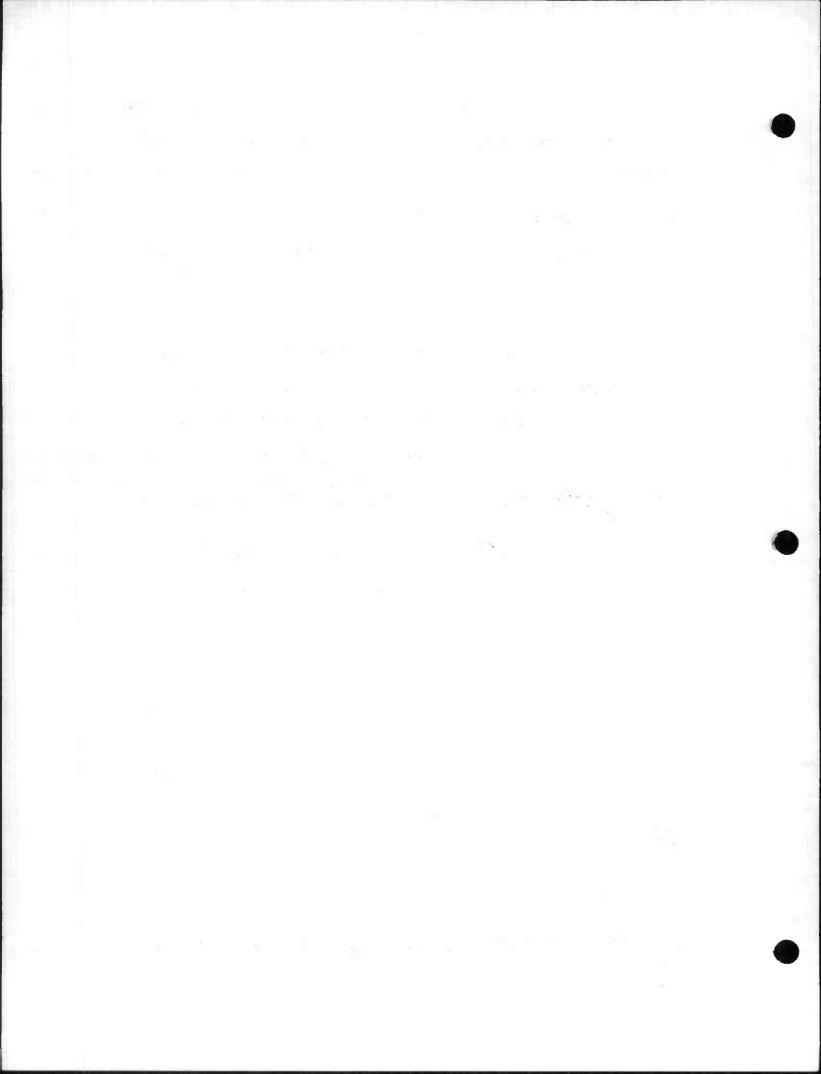
| BALTIMORE, MARYLAND 21215-0020 | ar death. Page 6 may be retained by the hospital or attending physician. | certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. | i examiner must be notified at once. | |
|--|---|---|--|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | V TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within crours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the is filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |

| | FOR STATE REGISTRAR | STATE OF MARY | | MENT OF H | | MENTA | L HYGIEN | _ | | | | | |
|--|--|--------------------------|--|---|--------------------|---------------------|---|---------------|---------------------------------|---|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | OF DEATH | | | 3. TIME OF DEATH | | | |
| , | Jan Sejna | | | | | Aug | ust 23 | YEAR | 11:55 A M | | | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE | OF BIRTH | | S. BIRTH | PLACE (State or Foreign | | | |
| | 579-72-6598 | 1 🔀 M 2 🗆 F | 70 YRS. | NONTHS DAYS | HOURS MIN. | | 12, 1 | 927 | Czec | h Republic | | | |
| | 9s. FACILITY NAME (If not institution, give s | itreet and number) | | 9b. CITY, TOWN C | R LOCATION OF D | | | 9c. COUNT | | | | | |
| DIRECTOR | 7217 Swansong Wa | y | | Bet | hesda | | | Mon | itgo | mery | | | |
| C E | 10a. STATE 10b. COUNT | Υ | toc. CITY, | TOWN OR LOCAT | ION | | | | | 10d. INSIDE CITY | | | |
| ¥ I | Maryland Mon | tgomery | Re | thesda | 200 | | | | | LIMITS? | | | |
| | 10e. STREET AND NUMBER | egomery | 1 10 | | ZIP CODE | | - | 1 TYES 2 K NO | | | | | |
| | 7217 Swansong | Wav | | | 20817 | | | Uni | ted | States | | | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT EVER | | 13. WAS DEC | ENDENT OF HISPAI | NIC ORIGIN | i? (Specify Yes | | 14. RACE | - American Indian, | | | |
| BYF | 1 Never Merried 2 Merried 3 Wildowed 4 Divorced | FORCES? 1 YES | | If yes, sp | 2 NO Specif | en, Pusrto I ly: | Rican, etc.) | | Spech | , While, stc. y: | | | |
| | | | | | | | | | | White | | | |
| | 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | 16a. DECEDENT'S U (Give kind of wo life. Do NOT use | rk done during mo | N st of working | 16b | KIND OF BUS | SINESS/INDU | ISTRY | | | | |
| ן ב | Elementary/Secondary (0-12) | College (1-4 or 5 +) | | 10.00 | | | | | | | | | |
| COMPLET | 17. FATHER'S NAME (First, Middle, Last) | 4 | Resear | cher | 18. MOTHER'S NA | | | | t D | efense | | | |
| ~ | Jan Seina | | | | | | | | | | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | - | 19b. MAILING A | ADDRESS (Street a | Ruzena | | ickova | | Code | | | | |
| 2 | Maria T. Sejna | | | | Way, Be | | | | | 20817 | | | |
| | 20s. METHOD OF DISPOSITION | 20 | | | | _ | | | nd 20817 City or Town, State | | | | |
| 1 | 1 Burisi 2 ACremetion 3 Rem 4 Donation 5 Other (Specify) | noval from State C6 | b. PLACE AND DATE OF metery, crematory or oth Ontgomery | er place) Au 2 | ust 25. | 1997 | Ret | heeda | M | Maryland | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIN | | M00831 | | | | c. Bethesda, Maryland when the Maryland Home / Chase, Inc. 7557 Wisconsin da, Maryland 20814-3501 | | | | | | |
| | Barbara Jom | / N | mence | Bethe | sda-Chev Bethe | y Cha | ase, I Marvl | nc. | 7557 0812 | Wisconsin | | | |
| | 23. PART I. Enter the diseases, or shock, or heart failure. | complications that cause | ilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, | | | | | | | | | | |
| | IMMEDIATE CAUSE (Final | and only one cades on | each mie. | | | | | | | Interval Between Onset and Death | | | |
| | disease or condition resulting in death) | | | l year | | | | | | | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| 5 | Saguardially, Het acaditions La Diabetes | | | | | | | | | | | | |
| 7 | if any, leading to immediate cause. Enter UNDERLYING Hypertension | | | | | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or injury that initiated events | | A CONSEQUENCE OF) | : | | | 5 years | | | | | | |
| Ē | reaulting in death) LAST | d Atrial Fib | rillation | | | | | | | l year | | | |
| . 11 | | | | | | | | | | 1 Jean | | | |
| Y | PART II. Other aignificant condition | a contributing to death | but not resulting in | the underlying | cause given in | Part i. | 24a. WAS AN PERFOR | | 24b. | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | | | |
| 5 | | | | | | _ | 1 - YES 2 | K NO | | OF DEATH? | | | |
| Σ | | | | | | | | | | 1 TYES 2 NO | | | |
| 2 | DID TOBACCO USE | CONTRIBUTE TO | CAUSE OF | | | | | | 1 | | | | |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | OTHER: | ACE OF DEATH (C) | | | | | | | | |
| 2 | 1 YES 2 NO 27. MANNER OF DEATH | 1 Inpatient 2 ER/Ou | | | • 5 X Residence | | | | | | | | |
| 2 | 1 🔀 Natural 5 🗌 Pending | (Month, Day, Year) | INJU | | RK? | 280. DES | SCRIBE HOW I | NJUHY OCCI | JHED | | | | |
| 2 | 2 Accident Investigation 3 Suicide B Could not be | 28s. PLACE OF INJUR | | 281. LOCATION (Street and Number or Rural Route Number. | | | | | | | | | |
| | 4 Homicide B Could not be | building, stc. (Sp. | ecify) | , | | | or Town, State) | | | note runoe, | | | |
| 29a. CERTIFIER (Check only one) 29a. CERTIFIER (Check only one) 29b. MEDICAL EXAMINER: On the best of sxamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| | | | | | | | | | |) and manner as stated | | | |
| | 29b. SIGNAPTIRE AND TITLE OF CENTING | -0 | | , | 29s. LICENSE NUI | | The precent an | | | | | | |
| 4 | Wee le | UW5 | | | | | | | | (Month, Day, Year) | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE OF D | EATH (ITEM 27) (Type I | Print) | D4199 |) | | Au | gusi | t 23, 1997 | | | |
| | Douglas C. Frank | | 2 Hungerf | | vo #20∧ | D. | okuri 11 | o M | 1 | 20050 | | | |
| | 31. DATE FILEDAUG 2 6"1997 | 32. REGISTRADE SIG | NATURES - | | ve, 1129A | , KO | CKVIII | e, Ma | гута | and 20850 | | | |
| | Ang 2 8 133/ | gulia David | Son-Mandell | • | | | | | | | | | |



State of Maryland / Department of Health and Mental Hygiene Q7 2721. Q

| | | | | | | Cei | rtificate | of | Death | | Reg. No. | 1 | 21240 | |
|----------------|--|----------------|--|---|--------------------------------|---------------------|-----------------------------|---|--------------------------|------------------------------------|---------------------------------|--------------------------------|--|--|
| | | . 1 | 1. Decedent's Neme (First, Middle, | Lest) | | | | | | 2. Date of I | | Vien | 3. Time of Death | |
| | Physic /Medi | | al Frank P. Sanders, Sr. | | | | | | | | t 18, 1 | 997 | 9:21 AM | |
| | Exami | | | | | | | | | | | ty of Deeth | | |
| | | | Shady Grove Adve | ntist Hosp | ital | | | | Rockvi | 11e | Mont | gomer | У | |
| | Funeral Director | | 5. Sociel Security Number 579-16-3551 Usuel Residence of Decedent | . Sex 7. Ag 1⊠M 2□F | e (In yrs. last i 78 | birthdey) Yrs. | If Under 1 Months | Year Deys | If Under 24 H Hours M | in. (Month, L | lirth Dey, Yeer) 30, 1919 | 9. Birth Cou Nort | plece (Stete or Foreign intry) h Carolina | |
| | yland | | 10a. State 10b. County | | 10c. City, To | own or Lo | cation | | | | | | 10d. Inside City Limits | |
| | a-fst | to | Maryland Montgo | mery | Pot | omac | | | | | | | 1 ☐ Yes 2X No | |
| | with the | al Director | 10e. Street end Number 12413 Over Rids | ge Road | | 10f. Zip Code 20854 | | | | | 10g. Citizen of Unite | | | |
| 020 | 72 hours effer death with the Maryland natural; or flems 23a or 28a-f show deal Examiner must be notified at | by Funeral | 11. Merital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced | 12. Was Decadent Armed Forces? 1 X Yes 2 1 If Yes, Give Year or Detes: | No | | Was Decede f Yes, specif | | | (Specify Yes or Nerto Rican, etc.) | 14. Re Ble Speci | eck, White | ican Indian, , etc. nite | |
| 21215-0020 | n 72 hours natural', | ted | 15. Decadent's | Education | | Se. Deced | dent's Usual | Occur | pation | | 16b. Kind of E | 16b. Kind of Business/Industry | | |
| 218 | d within 72 ho liene. r than "natur the Med cal | Completed | (Specify only highest (Elementary/Secondery (0-12) | college (1-4or 5 | i+) | life. L | DO NOT use | retire | during most of wid) | vorking | | | | |
| | filed within Hygiene. ther than | Sol | | 5+ | | nder | Secre | tar | y of Navy U.S. Govern | | | ment | | |
| Maryland | S de b s | B | 17. Father's Neme (First, Middle, La | st) | | | | | | | le, Meiden Sume | me) | | |
| 3 | Mer Merke Marke | P | Thomas Hadley | | | | | | | line Pov | | | | |
| Mai | T1 | | 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Ru | | | | | | | | | | | |
| | Heal m 2 | | Douglas G. Sanders/Son 12413 Over Ridge Road, 20e. Method of Disposition (Name of | | | | | | Date Date | 20c. Location | | | | |
| Baltimore, | pemit. Peges 1 e Department of Hec important: if item any injury or othe | | 20b. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) 20b. Pleas of Disposition (Neme of cemetery, cremetory or other pleas) Greenwood Cemetery Cremetory or other pleas) | | | | | | 1997 | | | rth Carolin | | |
| Bal | Depart import any in | | 21. Signeture of Funeral Service Licansee Robert A. Pumphrey Funeral Home/Rockville 300 West Montgomery Avenue Rockville, Maryland 20850-2805 | | | | | | | | | | | |
| | Physician /Medical Examiner | er | 23e. Part 1. Enter the disease, or co shock, or heart feilure. List on Immediate Ceuse (Final disease or condition resulting in deeth) | 2 | | | | | | ARCHO | | | Approximete interval Between Onset and Deeth | |
| | uted | Examiner | | b. COR | ONGR | y · | inte | ny | 915 | erse | | i | years | |
| 68760, | icete be executed physician end s the buriel-transit | | | | | | | | | | | 1 | | |
| × | 500 | n/Medical | Due to (or as e consequence of): | | | | | | | | - | | | |
| Bo | death ce | cial | Part II Other significant conditions | contributing to death by | ut not requising | y In the cu | do thin - an | uaa ah | rio la Dari I | 22h Di | d tobacco use a | a m d milita v d a d | to the cause of death? | |
| P.0 | that the de ed by the detached | / Physician | Pert ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | Yas 2 | • | bably 4 Unknow | |
| Vital Records, | e law requires has been sign je 2 should be | Completed by | | | | | | | | | s en eutopsy formed? | av Co | Vere eutopsy findings velleble prior to ompletion of cause f deeth? | |
| E | 0 - 0 | Con | | | | | | | | 1□ | Yes 25 No | 1 | ☐ Yes 2☐ No | |
| /ita | ifcian: The certificate rector, pag | Be | 25. Wes case referred to medical exeminer? | | | | | | 26. Plece of D | eeth (Check only | one) | | | |
| of | Physician: this certific ral director, | 은 | 1 Yes 25 No | Hospital: 1 inpatle | | Outpetien | | _ | 4 LI Nursing | Home 5□ Re | sidenca 6 □Ot | her (Speci | (y) | |
| Division o | ing After fune | Certification: | 27. Menner of Deeth 1 Naturel 5 ☐ Pending 2 ☐ Accident Investigat | | Year) 28b | . Time of Injury | M 28 | c. Injur Wor 1 🗆 | y et k? Yes 2 □ No | 28d. Describe | how injury occu | rred | | |
| Divis | | Sertific | 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine | 28e. Pleca of Inju building, etc | ury - At home, c. (Specify) | farm, str | eet, factory, | , offica 28f. Location (Street end Number or Rural City or Town, State) | | | al Route Number, | | | |
| | To the Hospital or within 24 hours efter To the Funeral Dir completely filled in | edicai (| 29e. Certifier (Check only one) Certifying I | Physician: To the best of eminer: On the basic of and manner ste | exemination r | anavor inv | restidetion. I | חשעת | DIDIOD DESTRUCC | curred at the time | spain and alecs | end due t | (a)ealist entire | |
| | within to the | Σ | 29b. Signeture and title of certifier | AM | N | n | 29c. | Licens | e number | 1 | 29d. Dete sign | ed (Month, | Dey, Yeer) | |
| 0 | + | | 30. Name end eddress of person wh | completed cause of a | hath (Item 220 | V) (Type | Print) | 1 3 | 100 | | 14045. | / / | 8, 1777 | |
| | | | DAVID Shour | 9901 10 | od bal | (D- | ten 1 | Bar | re Ror | Kville | Md 2 | 085 | 0. | |
| | Sta Registr | | 31. Dete filed (Month, Day, Year) AUG 2 | and manner ste | Signature Many | 100-7 | Brokett |) | | 1 | 17 2 | 00 | | |
| | 3 | | | | | | | | | | | | | |



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND # 20b, cms 8/21/97 AA CO HealtGertificate of Death 1. Decedent's Neme (First, Middle, Last) **Physician** Louise Mecedes Tomich /Medical Facility Nama (If not institution, giva streat and numb Examiner terpital North irunde If Undar 1 Yaar Months Deys 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 6 Sax Funeral Months 1 M ZOXF Director 174-12-8107 79 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10h County an "natural", or Itama 23a or 28a-f show Medical Examiner must be notified at Directo

| | 2. Dete of Deeth Month | Dey 19 | Year 1997 | 3. Time of Deeth |
|----------------------|---------------------------|-----------|--------------|-----------------------|
| 11 1 | Burnic | | nty of Death | rundel |
| If Under 24 Hours | Hrs. 8. Date of Birth | Year) | 9. Birth | place (Steta or Forei |

27249

1 ☐ Yas 2 X No

Nov 11 1917 Pennsylvania 10d. Insida City Limits MD Anne Arundel Annapolis

10e. Street and Number 10g. Citizen of Whet Country? 10f. Zlp Code 293 Cedar Lane 21403 United States 14. Race - American Indian 11. Maritel Status

12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yes, Give Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, atc.) Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 🏋 No Specity: White Specify: 3 ₩idowed 4 Divorced Yeer or Detes:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) 12 Home Homemaker

17. Fether's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Joseph T. Hill Bertha Brickner

19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)

293 Cedar Lane Annapolis, Maryland 21403 John Alvin Hill (Son) Date 20c Location - City or Town, State 20/97 Alexandria, VA 1 1997 Brentwood, Maryland 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) FMetroeshitepmfremator 1 ☐ Buriel 2 🎇 Cremetion 3 ☐ Removel from Stete 4 Donetlon 5 Other (Specify)

22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funerel Service Licensee

147 Duke of Gloucester St. Annapolis, MD 21401 min

and . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line.

SEPSIC

mediate Cause (Final disease or condition resulting in death)

Funeral

Be

Pages 1 and 2 should be nent of Health and Mental

Important: If Hem 27 is m any Injury or other trans-

Physician

/Medical

physician and I the burial-fran

井

Division of Vital Records, P.O. Box 68760

Physician/Medical Examine

ğ

Be

2

Certification:

3 Suicide

Examiner

FAILURE NAI

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury PHYSE

Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death?

1 Yee 2 No 3 Probably 4 Ninknown

24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed?

AUGUST

1 ☐ Yes 2 ☐ Ne 1 Yes 2 No

25. Was case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Ner

28a. Dete of Injury (Month, Dey Year) 27. Mennar of Deeth 28d. Describe how injury occurred 1 Naturel 5 Pending Invastigation 1 Yes 2 No 2 Applient

6 Could not be determined 28f. Location (Street end Number or Rural Routa Number, City or Town, State) Place of Injury - At home, ferm, street, fectory, olfice building, etc. (Specify) 4 Homicide

1 Lerthying Physician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the cause(s) end manner es steted.

2 Medical Examiner: On the besis of exeminetion and/or investigetion, in my opinion, deeth occurred et the time, date end piace, and dua to tha causa(s) end manner stated. 29e. Certifier (Check only

29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year)

D0051440 30. Name end eddress of person who completed cause of deeth (item 23e) (Type, Print)

NORTH ARUNDA HOSPITAL, 301 HOSPITAL DRIVE, CLENN BURNIE CADE 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture MA 21061

State Registrar

AUG 21 1997

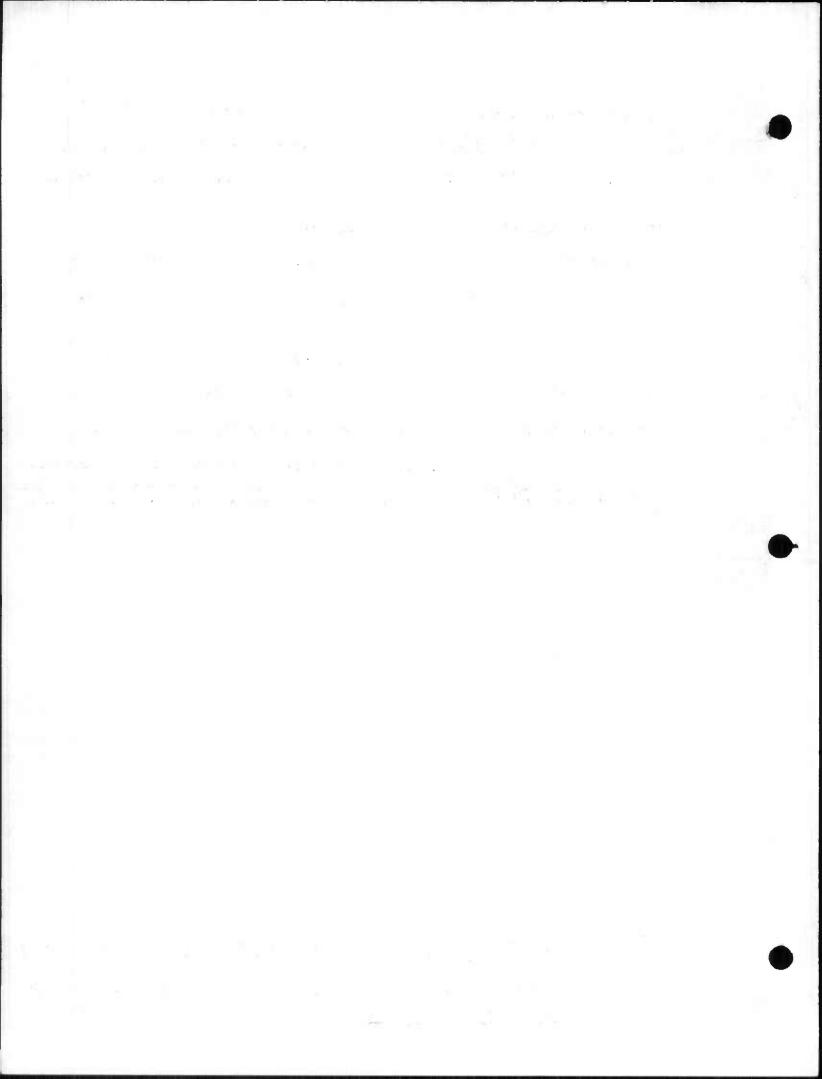


Dire

24 hours a

within 2 To the I 8

8



Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| Certif | M4- | -6 | 0 | 44 |
|--------|-------|-----|------|----|
| Lenn | icare | OI. | Deal | m |

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey **Physician** Month Year AUGUST 27, DIANNA SLACUM TAYLOR 1997 0030AM /Medicai 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner UNIVERSITY HOSPITAL SHOCK TRAUMA CENTER BALTIMORE CITY BALTIMORE If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 8. Dote of Birth (Month, Day, Year) 9. Birthplace (State of Mary Land) Mary Land 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□ M 3√X Months Days 16 Yrs 214-15-6057 Director Usual Residence of Decedent the Maryland 10b. County 10e State 10c. City, Town or Location rai', or items 23a or 28a-f show Examiner rount to notified at 10d. Inside City Limits TALBOT EASTON MD Director XYes 2□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21601 521 S. WASHINGTON ST. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes Æ(ZNo If Yes, Give Year or Dates: Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. be filed within 72 hours after de Ital Hygiena. ed other than "natural", or frem event, the Modical Examiner I 1 Never Married 2 Married 1 ☐ Yes 2 ₩ No by Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) HIGH SCHOOL 11 STUDENT -0traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peges 1 and 2 should be f nent of Health end Mental I nt: If item 27 Is marked of VIVIAN SLACUM GLENN LEE TAYLOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 521 S. WASHINGTON ST., EASTON, MD 21601 GLENN L. TAYLOR/ FATHER If item 27 or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XXBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) permit. Pege Department o Important: If is any Injury or FAIRVIEW CHURCH CEMETERY 8-30 CORDOVA, MD 21. Signature of Funeral Servica Licenses 22. Name end Address of Facility M FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 200 S. HARRISON ST., EASTON, MD 21601 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Lyurie disease or condition resulting in death) Examiner ince of) Examiner thet the death certificate be executed burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the buria Physician/Medical Due to (or es a consequence of): use igned by the ette Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ The law requires 24b. Were autopsy findings available prior to completion of cause of death? should Completed 24a. Was an autopsy performed? page 2 2 No VEYes 2□ No Hospital or Attending Physician: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ◯ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After 1 Natural 5 Pending 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) motorvehicle eftar death. collinea 1 Yes 2 No 2 Accident
3 Suicide investigation 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) R + 318, Breuce Comp. Ref. + 318, in by 4 Homicide within 24 hours e To the Funeral C completely filled filled strey edicai 29a. Certifier 1 Certifying Phyalclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ş 29b. Signeture and title of cartifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) O.C.M.E. AUGUST 27, 1997 Chute no Dennis J. 111 Penn Street, Baltimore, Maryland 21201

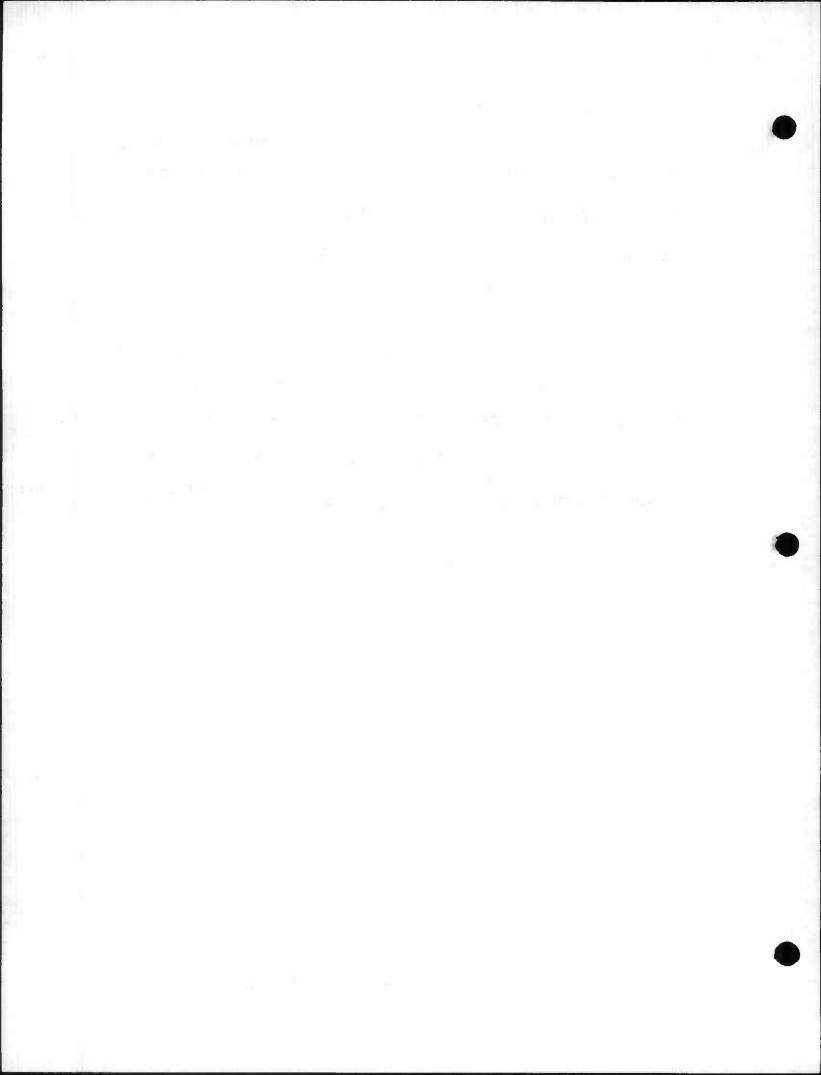
State Registrar

31. Date filed (Month, Day, Year)

AUG 29

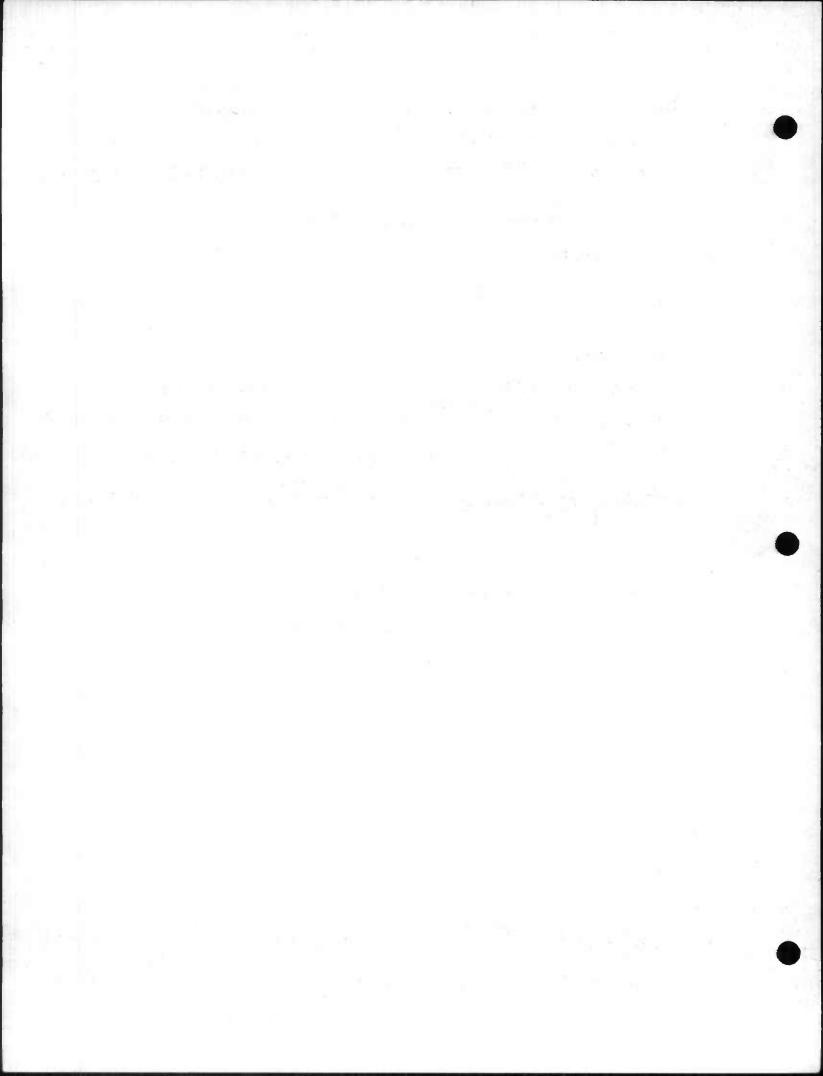
32. Registrar's Signature

wha Davidson-Randall



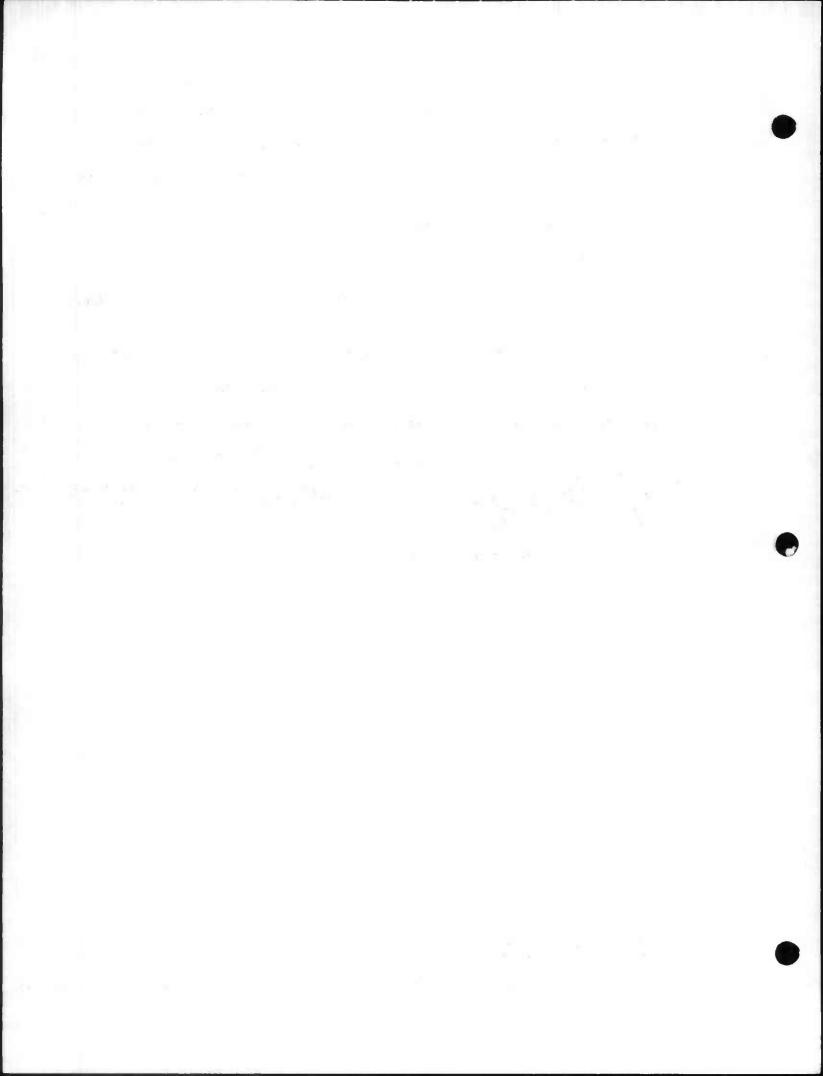
State of Maryland / Department of Health and Mental Hygiene 97 27251

| _ | | | | - X | Co | ertifica | | | | Reg. No. | | 21231 | | |
|-----------|--|---------------------|--|--|------------------------------------|-------------------------------|--------------------|--|---|--|-------------------------|---|-----|--|
| | Physic | ian | Decedent's Neme (First, Middle, Las | | T 11 | | | | 2. Dete of De Month | Dey | Yaar | 3. Tima of Deeth | | |
| J | /Medi | cal | Jonnette | Alice | Talle | 7 | | L City Town | August | | 1997 | 8 PM | | |
| | Exami | ner | 4a. Fecility Neme (If not institution, giva Suburban | Hospita. | 1 ′ | | 4 | | Location of Deat | | Cen and large | | | |
| ŀ | _ | | 5. Social Security Number 6. Se | - | In yrs. last birthde | v) If Unde | r 1 Year | Bethes | Sda S. B. Date of Bir | Mon | tgon | | ion | |
| ā | Funeral Director | | | THE NOTE: | 74 Yrs. | Months | | Hours Min | Jan 1 | th ey, Year) .3,1923 | Mar | plece (State or Foreintry) Cyland | gri | |
| | yland | | 10a. Stete 10b. County | 1 | Oc. City, Town or | Location | | | | | | 10d. Inside City Limit | ts | |
| | e Mar | ctor | Md Montgo | mery | Silv | er Sp | prin | g | | | XXYes 2□N | ю | | |
| | or 28 | Ore | 10e. Street end Number | | | 10f. Zi | p Code | | | 10g. Citizen of | Whet Cour | ntry? | | |
| | ath w | <u>a</u> | 710 Kerwin | Rd, | | | 0901 | | | | .A. | | | |
| 120 | 72 hours after death with the Maryland naturel; or items 23a or 28a-f show deal Examiner must be notified at | by Funeral Director | 11. Marital Status 1 □ Never Married 2 □ Married 3 🎛 Widowed 4 □ Divorced | 12. Wes Decedant Ev Armed Forces? 1 ☐ Yes 2 🔯 No If Yas, Give Yeer or Dates: | | | | ispenic Origin? (3 n, Mexican, Puer Specify: | Specify Yes or No to Rican, etc.) | Specif | ck, White, | | | |
| 5-0020 | 72 hours "naturel", | 8 | 15. Decedent's Edi | | el Occup | etion | | 16b. Kind of B | | Lack | _ | | | |
| 215 | - 3 | Completed | (Specify only highest gred Elementery/Secondary (0-12) | de completed) College (1-4or 5+) | (Give kind of work done during mos | | | during most of wo | orking | | | | | |
| 2121 | | mo. | 10th Grade | College (1-401 54) | Do | mest | ic | | | None | ne | | | |
| pu | be filed ital Hygi d other event, | Be | 17. Fether's Neme (First, Middle, Last) | | | | | 18. Mother's Ne | me (First, Middle | , Malden Sumer | ne) | | | |
| 1 | should be filed within and Mantal Hygiena. marked other than umatic event, the Mantal and a Man | 2 | | Kelly | | - | | Bes | | dson | | | | |
| Maryland | 0 0 0 0 | | 19e. Informent's Neme/Relationship (7) Gilbert N. Ke | | 1 | | | | | | | d 20901 | | |
| | other tr | | 20e. Method of Disposition | ricy | 20b. Pleca of Dis | | | | Dete | 20c. Location | | | _ | |
| Baltimore | permit. Pages Department of I Important: If It any Injury or o | | 1 N Burial 2 □ Cremation 3 □ I 4 □ Donetion 5 □ Other (Specify | 1 | Gate 0 | f Hea | aven | Cem. | | 28/97 Silver Spring, Md | | | | |
| Bal | Depar Impor any Ir | | 22. Name end Address of Fecility Snowden Funeral Home P.A. 20850 246 N. Washington St, Rockville, Md | | | | | | | | | | | |
| | | | 23a. Part1. Enter the diseasa, or come shock, or heert feilure. List only | licetions that caused the | e death. Do not e | nter the mo | de of dyin | g, such es cardie | c or raspiretory a | rrest, | | Approximete Intervel Between | | |
| | Physician /Medicai Examiner | | Immediate Ceuse (Finel disaasa or condition resulting in death) e. Pasemonia | | | | | | | | | Onset end Deeth | | |
| | | | | | | | | | | | | 10 days | | |
| | | ē | | Di | ue to (or es a cons | equence of) | | / | 1 | | | 9 140 | | |
| | uted 3 ansit | Examiner | | b. Ceny | s/Inc | her | N | farl | ne | | - | Lyon | | |
| ó | ificate be axecuted g physician and as the burial-transit | | | | | | | | | | | | | |
| 68760, | tta be nysicia he bu | edlcai | | | | | | | | | | | | |
| | - C+ 0 | - | resulting in deem) Lest | | | | | | | | | | | |
| Box | attending | lan/ | | d | ,,, | | | | | | 1 | | | |
| | the a | Physician/N | Pert II. Other algnificant conditions co | ntributing to death but | not resulting in the | underlying | cause give | en in Pert I. | 23b. Dld | Id tobacco use contribute to the cause of death? | | | | |
| P.0 | that the death ed by the atte detached for | | | | | | | | 1 🗆 | Yes 2 No | 3 Pro | bably 4 Onkno | wn | |
| Records, | 8 E 8 | d by | | | | | | | 24e Wes | en eutopsy | 24b. W | ere eutopsy findings | s | |
| 00 | v requir been s should | Completed | | | | | | | perfe | ormed? | av | veliable prior to empletion of causa deeth? | | |
| Re | The law ate has page 2 | E G | | | | | | | | Yea 2 No | | | | |
| | | | 25. Wes case referred to medical | | | | | 26 Place of Do | eth (Check only | 30 11 11 | 11 | ☐ Yea 2☐ No | | |
| of Vital | ysiclan: is certifica director, | To Be | exeminer? | Hospital: | 2 ☐ ER/Outpeti | ient 3 D | OA Oth | 04: | Home 5 Resi | | ner (Speci | (v) | | |
| 0 | g Physics result di | | 27. Manner of Deeth | 28e. Dete of Injury (Month, Dey | | | 28c. Injun Worl | | 1 | how injury occur | | " | | |
| 0 | tending Ph leath. lor: After thi the funeral | atlo | 1 ► Maturel 5 □ Pending investigation | (Month, Dey | oar/ Injury | м | | Yes 2□No | | | | | | |
| Division | r Atter de l'recto | Certification: | 3 ☐ Suicida 6 ☐ Could not be 4 ☐ Homicide determined | 286. Piece of injury - At home, ferm, street, factory, office 281. Location | | | | | | Straet end Num wn, Stete) | ber or Run | al Routa Number, | | |
| 0 | oltal ours af | | | | | | | | | | | | | |
| | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completaly filled in by the funeral director. | edicai | 29a. Certifier 1 ☐ Cartifying Phy (Check only one) 2 ☐ Medical Exami | alctan: To the best of r nar: On the basis of ex end menner stete | caminetion end/or | eth occurred Investigetion | et the tim | ne, dete end plec pinion, death occ | e, end due to the urred et the time, | deta and plece, | enner as s and due t | teted. o the cause(s) | | |
| | o the o the omple | ₹ E | 29b. Signeture and file of certifiar | M10 | ų. | 29 | c. License | number | | 29d. Data signe | ed (Month, | Dey, Year) | | |
| | 8 | | My how | _ ''') | | | D4 | 2222 | | August | - 24 | 15 1997 | | |
| | U | | 30. Neme end eddress of person who | empleted ceuse of dea | th (Item 23e) (Type | e, Print) | 2 14 | -0 | 1 .00 | | - | 15 1997 | | |
| | | | M. CHOUDRY | 11119 | KOCKUL | | | 1200 | Kville | , mi) | a | 1082 2 | | |
| | Sta | ite | 31. Dete filed (Month AGG 2) 6 1 | 32. Registrati | Signature | 0 | | | | - | | | | |
| | Registr | ar | ,,, | 7 | Inclosed | milaria | | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 27252

| _ | | | 14 | | | | Cei | titicat | e of | Death | | | Reg. No. | | | |
|--------------------------------|--|----------------|---|--|--------------------------------|-----------------------|---------------------|---------------------------|------------------|-----------------------------------|-----------------------|--------------------------------|----------------------------|-------------------------------------|---|--|
| ı | Physic | an | Decedant's Nama (First, Middla) | , Last) | | | | | | | | 2. Date of D Month | eath Day | Yaar | 3. Tima of Death | |
| Į, | /Medi | | | | | Tissot | t | | | | | August | 28, | 997 | 10:40 AM | |
| 9 | Examii | ner | 4a. Facility Nama (If not institution, | | um <i>ber)</i> | | | | | 4b. City, Town, or Location of De | | | th 4c. Co | unty of Deeth | | |
| L | | | 11408 Hounds | | | | | 811-1- | 1 | Rock | | Y | | ntgome | | |
| | Funeral | | 5. Social Security Number None | 6. Sax 1⊠M 2□ F | | n yrs. last bir 84 | thday) Yrs. | If Undar Months | | | Min. | 8. Data of Bi (Month, D | ay, Year) | 9. Birth Cou | placa (Stata or Foreign intry) | |
| | Director | | Usuai Rasidance of Dacedant | | <u> </u> | | | | | | | March 6 | , 1913 | B Fra | ance | |
| | /and | | 10a. Stata 10b. County | | 10 | Oc. City, Tow | n or Lo | cation | | | | | | | 10d. Inside City Limits | |
| | Man | tor | Maryland Monts | gomery | | Rock | vi1 | 1e | | | | | | | 1 ☐ Yes 2 🎇 No | |
| | h the | Director | 10e. Street and Number | | | 11001 | V J. J. | 10f. Zip | Coda | | | | 10g. Citizer | of What Cou | intry? | |
| | h wit | O | 11408 Hounds W | ay | | | | | 20 | 852 | | | F | rance | | |
| | deat | Funeral | 11. Marital Status | 12. Was De | cedant Eva | r in U,S. | 13. \ | Vas Daced | | | igin? (Sp | ecify Yas or N Rican, etc.) | | Race - Amar | | |
| 20 | or it | | 1 ☐ Nevar Married 2 【X Marrie | ed 1 ☐ Yas If Yas, G | 2 X No | | | Yas | | | | rican, etc.) | | Bleck, White | | |
| 00 | within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show ha Medical Evanties must be notified at | d by | 3 Widowed 4 Divorcad | Yaar or | | | | | | оросиу. | | | 30 | ecify: W | hite | |
| 5 | nath | Completed | 15. Decedant's (Specify only highas) | s Education grada complated |) | 16a. | (GIVA | lant's Usua kind of wo | rk dona | dunna mos | t of work | ring | 16b. Kind | of Businass/In | ndustry | |
| 12 | withir ene. than | dm | Elamantary/Secondary (0-12) Collega (1-4or 5+) 3 Engineer | | | | | | | | Chan | 1 T. J. | | | | |
| 0 | Hygi ther ther | | 17. Fathar's Nama (First, Middla, L | | | | | Eng | THEE | | ar's Nam | a (First, Middle | - | 1 Indu | stry | |
| lan | d be entai ced o | o Be | Paul Tissot | , | | | | | | | | Daunas | , marada r od | · rainay | | |
| JI. | Should Man | T _o | 19a. Informant'a Name/Ralationsh | ip (Type, Print) | | 19b | . Mailin | o Addrass | Street | | | | per City or To | own State Z | in Code) | |
| Ž | nd 2 with a 27 is | | 19a. Informant'a Name/Ralationship (Type, Print) Danielle Kolobow Tissot 11408 Hounds Way, Roc | | | | | | | | | 0852 | | | | |
| re, | othe othe | | 20a. Mathod of Disposition | | | | | . 141 /01 | | | | | | 20c. Location - City or Town, State | | |
| E | Page nent c nrt: M nry or | | 1 ☐ Burial 2 ☒ Cramation 4 ☐ Donation 5 ☐ Other (Spi | | | Montgo | mer | v Cre | emat | Augus | st 30 | , 1997 | Bethe | sda. M | aryland | |
| Baltimore, Maryland 21215-0020 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e4 show important: If item 27 is marked other than "hatural", or items 23e or 28e4 show important in items and the control of the profit of an analysis in the profit of | < | 21. Signature of Stineral Service L | conseg | | nonege | 22 | Nama an | d Addra | ss of Fecili | hv | | | | | |
| m | Depar Impor any ir | | D 11/1/18 | 0/10 | , M | 00846 | Ro | bert A 57 Wis | A. Pu | mphrey | Fune | eral Home Rethesda | e/Bethes | da-Chev | y Chase, Inc 814-3501 | |
| | | П | 23a. Part 1. Entar the disaasa, or o shock, haart failura. List o | omplications that | ulusad tha | daath. Do r | | | | | | | | 200 | Approximata | |
| | Physician | | SHOOK OF HABIT IAIIUIA. LIST O | illy offacaus of | Juli IIII a. | | | | | | | | | 1 | Intarval Batwean Onset end Death | |
| | /Medicai | | Immediata Causa (Final disaasa or condition Glioblastoma Multiform | | | | | | | | | | | 1 | Months | |
| | Examiner | | rasulting in death) Dua to (or as a consequence of): | | | | | | | | | | | | | |
| | D === | Examiner | | - b | | | | | | | | | | | | |
| | certificate be executed nding physician and use as the bunal-transit | хап | Sequentially list conditions, Dua to (or as a consequence of): | | | | | | | | | | | | | |
| 68760, | be ex | | Sequantially list conditions, if any, leading to Immediata cause. Entar Undarlying Causa (Disease or injury that initiated avants | C | | | | | | | | | | | | |
| 387 | phys the | edical | that initiated avants resulting in daath) Lest | | Due | to (or as a c | onsequ | uance of): | | | | | | | | |
| X | ding rse as | υ/Μ€ | | d | | | | | | | | | | | | |
| m | atter affor u | clar | Death Other death, and the | | | | | | | | | | | j | | |
| 0 | res that the death signed by the atter i be detached for i | Physicia | Part ii. Other significant condition | s contributing to d | eath but no | ot rasulting in | tha ur | idariying ci | ausa giv | an in Part I | | | | | to the cause of death? | |
| 10 | s that ned t | by P | | | | | | | | | | 10 | Yes 2 l | lo 3□Pro | bably 400 Unknown | |
| Ď | | Pa | | | | | | | | | | 24a. Was | an autopsy | | ara autopsy findings | |
| ပ္တ | aw requ as been 2 shoul | plet | | | | | | | | | | реп | ormed? | C | vellebla prior to omplation of causa daath? | |
| Z. | 9 7 9 | Completed | | | | | | | | | | 10 | Yas 2K)N | | ☐Yes 2☐No | |
| Vital Records, P.O. | | Bec | 25. Was casa rafarrad to medical | | | _ | | | - | 26. Piaca | of Deat | h (Chack only | | | | |
| > | 0 0 | To | axaminar? 1 ☐ Yas 2 ☒ No | Hospital: | inpatiant | 2 ER/Ou | tpatien | 3 DO | Oth | 10F | | ma 5 🕅 Res | | Othar (Speci | fy) | |
| 0 | ding Ph. After thi funeral | | 27. Mannar of Death 1 X Natural 5 ☐ Panding | 28a. Data | of Injury | | Tima of | 2 | 8c. injur Wor | ry at | | 28d. Dascribe | how injury or | curred | | |
| 010 | Attending or death. ector: After by the fune | atio | 2 ☐ Accidant invastiga | | | | , , | М | | Yes 2 | No | | | | | |
| Division of | I or Attending after death. Director: After in by the fune | Certification: | 3 ☐ Suicida 6 ☐ Could no 4 ☐ Homicida datarmin | ad 28a. Plac | e of Injury - ling, atc. (S | At home, fa | rm, stra | at, factory | , offica | | i | 28f. Location (City or To | Straat and N wn, Stata) | u <i>mber</i> or Rur | al Routa Number, | |
| | | | | | | | | | | | | | | | | |
| | Hospita 24 hours Funeral stely filled | edicai | (Check phry 2 Medical E. | Phyaician: To the caminar: On the b | pasis of axa | amination and | , daath d/or inv | occurrad a astigation, | at tha tir | ma, data an pinion, daa | d place, th occurr | and dua to tha | causa(s) and data and pia | f mannar as a | stated. o tha cause(s) | |
| | To the Hospital or At within 24 hours after d to the Funeral Direct completely filled in by | Med | 29b. Signeture and title of cartifiar | and mar | nnar stated. | | | 1000 | | se number | | | | gned (Month, | | |
| | 15 (10) | - | Significant of Cartillar | 12 | . 1 | | | 2.90 | | | | | | | | |
| | | | 20 Named | 1 the | 5 | | _ | | D30 | 692 | | | Augus | t 28, | 1997 | |
| | | | 30. Nama and address of person w | 1 | 1.5 | 000 01 | 1 | | 70 D | 024 # | 305 | Do oler- | 111. | Marri - | nd 20050 2210 | |
| | Sta | te | Gabriel A. Berro | 0 100-32.5 | e, ID. | ZUU DII Signatura | iauy | 6101 | ve K | .vau # | JUJ, | KOCKV. | rrre, 1 | лагута | 114 20630-3218 | |
| | Registr | | חטעע | 9 199/ | Juli | Davids | n-7 | anden | | | | | | | | |
| | | | | | | | | - | | | | | | | | |



State of Maryland / Department of Health and Mental Hygiene 97

ene 97 2725:

| | | | | | | Ce | rtificate d | of Death | 7 | | Reg. No. | | | |
|---------------------|---|-------------------|---|---|-------------------------------------|--------------------------------|--|---|----------------------------|---|---------------------------------|------------------------------|--|--|
| | Physic /Medi | | 1. Decedent's Name (First, Middle CLEO | e, Last) VAL | ENT | E | | | | A WGU | Dey | 1997 | 3. Time of Deeth | |
| | Exami | | 4a. Fecility Neme (If not Institution Anne Arundel M | n, give street and num | ber) | | | | own, or Lo | cation of Dee | th 4c. Count | y of Death Arund | de l | |
| | Funeral Director | | 5. Social Security Number 071-20-6751 | 6. Sex 7 1 □ M 2 ☒ F | . Age (in yrs. 81 | last birthdey Yrs. | Montha De | er If Unde | r 24 Hrs. | R Date of Bi | | | lece (State or Foreign try) EW York | |
| | | | Usuel Residence of Decedent 10a. Stete 10b. County | | 10c. Cit | y, Town or L | ocation | | | | , | | Od. Inside City Limita | |
| | Ne Ma | Director | | | 1 ★ Yes 2 □ | | | | | | | | | |
| | h with th | | 10e. Street and Number 2017 N Street, | NW | | | 10f. Zip Cod | | | 10g. Citizen of Whet C | | | try? | |
| 020 | filed within 72 hours after death with the Maryland Hygiena. ther than "natural", or flems 23a or 28a-f show but, the Medical Examinet must be notified at | by Funeral | 11. Merital Stetus 1 □ Never Merried 2 □ Merr 3 ☑ Widowed 4 □ Divorced | MAKE ON | | S. 13. | Wes Decedent If Yes, specify C | | | ecify Yes or N Rican, etc.) | 14. Ra Ble Speci | ca - America ck, White, e | | |
| Maryland 21215-0020 | s 1 and 2 should be filed within 72 hours Health and Mental Hygiena. Item 27 is marked other than "natural", other traumatic event, the Medical Exa | Completed | 15. Deceden (Specify only highe Etementery/Secondery (0-12) | t's Education st grade completed) | 4or 5+) | 16a. Dece (Give life. | edent's Usuel Oc e kind of work do DO NOT use re | cupetion ne during mo tired) | st of working | | | | | |
| 12 | her th | | 17 Eather's Name /First Middle | 1 2 2 | | | Sales | S Jewelry Store 18. Mother's Neme (First, Middle, Meiden Sumame) | | | | | | |
| and | d be f | Be | 17. Father's Neme (First, Middle, Panayiotis Ni | ikitakis | | | | | | i anopol | | төј | | |
| 7 | 2 should be filed within and Mental Hygiena. is marked other than aumatic event, to M | To | 19e. Informent's Neme/Reletions | | | 19h Meil | ing Address (Str | | | | | State Zin | Code) | |
| | 1 and 2 s Health ar om 27 is ther trau | | Carmen O'Connor | | on | | N Stree | | | | - | 0036 | | |
| ore, | of Hail | | 20e. Method of Disposition | | 20b. P | | osition (Neme or metory or other | | 1 | Dete | 20c. Location | - City or To | wn, Stete | |
| m | Page nat: H | | 1 ☐ Buriai 2)X Cremetion 4 ☐ Donetion 5 ☐ Other (S | 3 □Removel from St pecify) | 1919 | | ke Crem | | 8 | -23-97 | Beltsv | ille, | Maryland | |
| Baltimore, | permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once. | | 22. Name and Address of Facility Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20 | | | | | | | | | | | |
| 68760, | Certificate be executed ding physician and isa as the burial-transit | /Medical Examiner | Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | e | Due to (o | r es e conse | quence of): | | JSU | FFIC | 1 ENC | | | |
| XO | - 63 | an/Me | | d | | | | | | | | | | |
| , P.O. B | lew requires that the death as been signed by the atten t.2 should be detached for u | by Physician | | | | | | | | | | | | |
| of Vital Records, | law require has been sig | Completed t | | | | | | | | 24e. Wei | s en autopay ormed? | con | ra autopsy findings tilable prior to apletion of cause death? | |
| alF | The sta | | | | | | | | | 10 | Yes 2 No | 1 | Yes 2□ No | |
| ž | Physician: T this cartificat ral director, pa | o Be | 25. Was case referred to medical exeminer? 1 ☐ Yes 2 € No | Hoenitel: 4 | noticet 2 | ED/Outratio | nt 3 DOA | Other | | (Check only | | has (Canall | 4) | |
| | The Line | ation: To | 27. Menner of Deeth 1 Alaturel 5 Pendin 2 Accident investig | 28e. Date of (Month, | | 28b. Time of Injury | of 28c. I | njury at Work? | 2 | | idenca 6 □Ot how injury occu | | 7 | |
| Division | X # # 5 | Certification: | 3 Sulcide 6 Could determ | inad 288, Piece 0 | f Injury - At ho , etc. (Specif) | ome, ferm, at | reet, fectory, offi | се | 2 | 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) | | | | |
| | To the Hospital of within 24 hours a To the Funeral D completely filled | edical C | 29e. Certifier (Check only one) Certifyin | g Physician: To the be Examiner: On the bas end menne | is of examinet | wledge, deet tion and/or in | th occurred at the | e time, dete e ny opinion, de | nd piece, a eth occurre | and due to the | ceuse(s) end m | enner es st , and due to | ated. the cause(a) | |
| | within To th | Me | 29b. Signature and the of certifie | 00 | | | | ense number | | | 29d. Dete sign | ed (Month, I | Day, Year) | |
| | 10 | | 1 Tel | Melle | 14 | | D | 163: | 54 | | August | 22, | 1997 | |
| | | | 30. Name and address of person | | | | | | | | | | | |
| | | | Enser Cole, MD, | 900 Bestg | ate Ro | ad, An | napolis | , Mary | land_ | 21401 | | | | |

- tronger to by

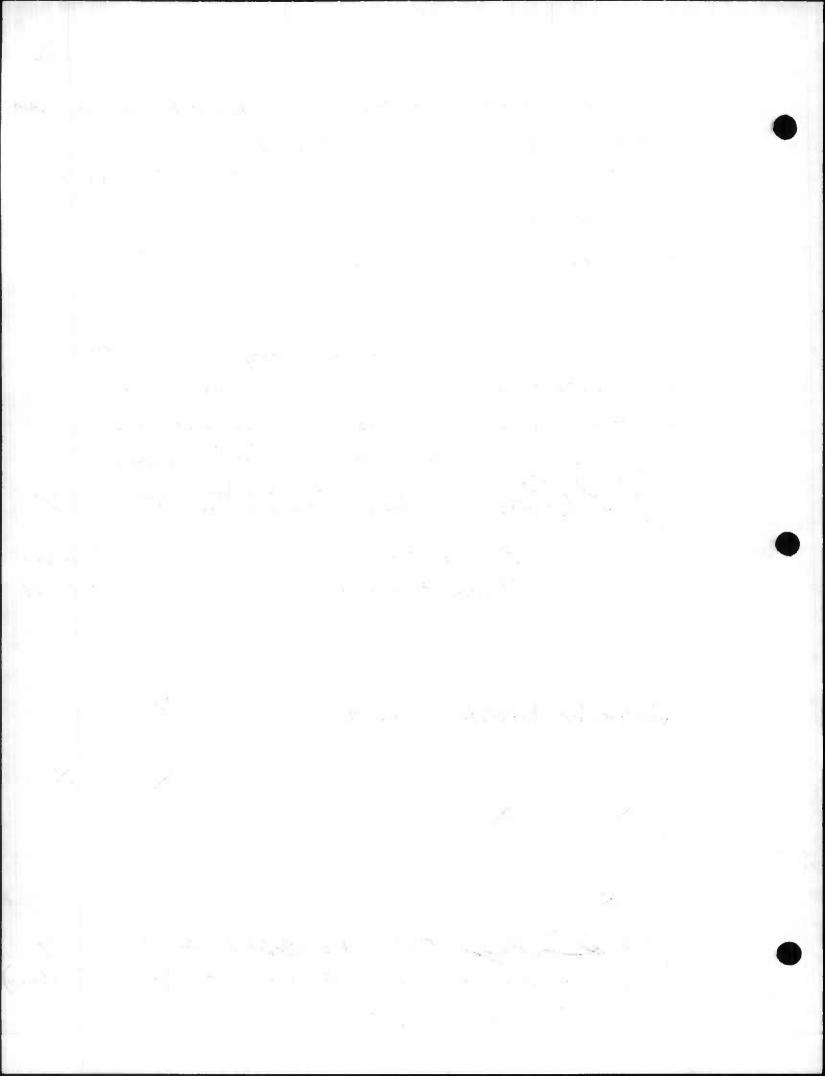
State of Maryland / Department of Health and Mental Hygiene 9.7

27254

| | | | | Certificate of L | Death | Reg. No. | 1 21234 |
|-----------|---|------------------|--|--|---|-----------------------------|--|
| | Physic /Medi | | 1. Decedant's Neme (First, Middle, Last) Watkins, Alven | ta E | 2. Dete of Month | Day 19 | Year 2300 |
| 1 | Exami | ner | 4e. Fecility Neme (If not institution, give street and number) Ann Arundel Medical | auter | b. City, Town, or Location of De ANN apoli | S Ann | Arundel |
| | Funeral Director | | 5. Sociel Security Number 6. Sex 7. Age (In yrs. les 1 ■ M 2 ■ F 81 | t birthday) If Under 1 Year Months Deys | Hours Min. 8. Dete of (Month, MAY 9 | Birth Dey, Year) 1916 | Birthpiece (State or Foreign Country) MARYLAND |
| | e Marylend 3e-f show affied at | Director | 10a. State 10b. County 10c. City, 1 | Town or Location APOLIS | | | 10d. Inside City Limits 1XXYes 2 □ No |
| | 72 hours after death with the Marylend natural, or items 23a or 28a-f show deal Examiner must be notified at | Funeral Dire | 10e. Street end Number 130 HEARNE RD. APT. 912 11. Marltai Status 12. Was Decedent Ever in U.S. | | 1401 spenic Orlgin? (Specify Yes or n, Mexicen, Puerto Ricen, etc.) | 10g. Citizan of V | US e - Americen Indian, |
| 5-0020 | 72 hours after natural, or ite | þ | 1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 💯 ☐ ∭ o If Yes, Give Yeer or Detes: | 1 ☐ Yes 2X No | Specify: | Specify | BLACK |
| 21215- | within ene. than | Completed | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) | 16e. Decedant's Usuel Occupa (Give kind of work done d life. DO NOT use ratired, OYSTER SHUCKER | uring most of working | | ELD OYSTER & |
| Maryland | should be filed ind Mental Hygis i marked other umatic event, the | To Be C | 17. Fether's Neme (First, Middle, Last) VERNON EASTON | | 18. Mother's Neme (First, Mid- | dle, Meidan Surnam | |
| | s 1 end 2 sho of Health and frem 27 Is ma other traums | | LILLIAN SANDERS (DAUGHTER) | 19b. Mailing Addrass (Street at 947 FRANKLIN More of Disposition (Name of | ANOR RD. CHUF | CHTON, MI | |
| altimore, | Page nent or int: If I | | Cert | netery, cremetory or other plece | METERY 8/25/97 | | |
| Ba | Demit. Departn Imports any Inje | | 23e. Pert 1. Enter the disease, or complications that caused the death. shock, or haert failure. List only one cause on each line. | WM. REESE & 821 WEST ST | SONS MORTUARY ANNAPOLIS, M | ID. 21401 | Approximete |
| | Physician /Medical | | Immediate Cause (Finel disease or condition | ac arre | , | | Interval Between Onset and Deeth |
| | Examiner | Examiner | Due to (or a Canda | s a consaquence of): Fac dy | 8Rythmic | | weeks |
| 68760, | icate be executed physician and s the burial-transit | | If eny, leeding to immediata cause. Entar Undariying Ceuse (Disaase or Injury that initieted events | s e consaquance of): Many al s e consequence of): | rfery di | Sease | years |
| Box 68 | eath certifica ettending phi for use es th | an/Medical | resulting in daeth) Last | | | | |
| P.O. | The law requires that the death certificate be executed the has been signed by the ettending physician and page 2 should be deteched for use as the bunal-transit | by Physician/ | Part II. Other significent conditions contributing to death but not resulting. Diabetes Mellitte | | | id tobacco usa coi | ntribute to the cause of deeth? |
| Records, | e law require has been sig ge 2 should b | Completed | | | | es en eutopsy erformed? | 24b. Wera eutopsy findings aveileble prior to completion of ceuse of deeth? |
| Vital R | ician: certifica rector, | o Be Con | 25. Was cesa raterred to medical axeminer? Hospital: | Othe | 26. Plece of Deeth (Check on | | 1 ☐ Yes 2 ☐ No |
| of | Attending Physic death. ector: After this by the funeral di | | 27. Mennar of Deeth 27. Mennar of Deeth 1 Active: 5 Pending (Month, Dey Year) 2 Accident investigation | 3b. Time of lnjury Work | 4 ☐ Nursing Home 5 ☐ H | asidance 6 Other | *************************************** |
| Division | pital or Atte | i Certification: | 3 Suicide 6 Could not be datarmined 28a. Place of Injury - At home building, atc. (Specify) | | City or | Town, State) | er or Rural Route Number, |
| | To the Hospital or / within 24 hours after To the Funeral Dire completely filled in b | Medical | 29a. Certifiar (Check only one) 1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the best of examination end menner steted. 29b. Signetura end title of certifier | ndga, daath occurred at the time of end/or investigetion, in my op 29c. Licansa | inion, daath occurred et the tim | ne, date and place, | annar as stated. end due to the causa(s) d (Monthy Dey, Year) |
| | ->=0 | | Kak Apperovitedio | 3e) (Type, Print) | D37291 | 8/4 | 0/97 |
| | Sta | | Kari Alperovitz Bichell Ma 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture | 0 /340 wed | 1)37°291 isville Rd W | est Rive | 4 40 20778 |
| DH | Registr | | AUG 2 1 1997 Julia David | Jar-Nauton | | | |

State of Maryland / Department of Health and Mental Hygiene 97 27255

| | AMEND | # | 19a cms 8/19/9 | | dealt | h Cei | rtificate o | f Death | R | eg. No. | | |
|------------|---|------------------|--|---|----------------|------------------------|--------------------------------------|--|--|------------------|--------------------------|--|
| | Physic | lan | Decedent's Name (First, Middle, Li | Wiggle | | u X /- | Cm | | 2. Date of Dea Month | th Day | Yaar | 3. Tima of Death |
| J | /Medi | | Donald | | | , | Sr. | | August | - | 997 | 11:55AM |
| ч | Examir | ner | 4a. Facility Name (If not institution, gi | | | | | 4b. City, Town, or I | | 4c. County | of Death | |
| Н | Funeral | | THE JOHNS HOPKIN 5. Social Security Number 6.3 | | ge (In yrs. la | st birthday) | If Under 1 Ya | BALTIMORE ar If Undar 24 Hrs. | 8. Data of Birth | | a Rirthn | slace (State or Foreign |
| | Director | | | 1ÅM 2□F | 72 | Yrs. | Months Day | /s Hours Min. | 8. Data of Birth (Month, Dey Dec 18, | 1924 | _ | place (Steta or Foreign ptry) necticut |
| | Mand Mand | | 10a. State 10b. County | | 10c. City, | Town or Lo | cation | | | | 1 | Od. Inside City Limits |
| | death with the Maryland ms 23s or 28s-f show | tor | MD Anne Ar | rundel | | Sever | na park | | | | | 1 ☐ Yas 2 🗑 No |
| | or 28 | irec | 10e. Street and Number | | | | 10f. Zip Code | • | 1 | 0g. Citizen of \ | What Cour | itry? |
| | 23a | la | 205 Birch Court | | | | 2114 | 46 | | US | SA. | |
| | | Funeral Director | 11. Marital Status | 12. Was Decedent Armed Forces? | , | | Was Decedent of f Yes, specify Co | f Hispanic Origin? (Spuban, Mexican, Puert | pecify Yes or No- Rican, atc.) | | e - Americ ck, White, | an Indian, atc. |
| 020 | hours efter death with the Marylan urel', or items 23s or 28s-f show al Examiner must be notified at | by F | 1 ☐ Nevar Marriad 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 X Yas 2 ☐ If Yes, Give Yaar or Dates: | No WWI | I | 1□Yes 2OXN | lo Specify: | | Specify | ·: [| Vhite |
| 21215-0020 | | | 15. Decedent's E | ducation | | 16a. Deced | dent's Usual Occ | cupation | | 16b. Kind of B | usiness/Inc | dustry |
| 21 | | Completed | (Specify only highest gri Elementary/Secondary (0-12) | de com <i>pleted)</i> College (1-4or | 5+) | life. L | DO NOT use reti | , | , | | 191 | 1 - 2 |
| | ygien ygien ver th | Con | | 5+ | 1 | Nation | nal Secu | rity Agend | - y | U.S. Go | | ient |
| and | H left H of the off | Be | 17. Father's Name (First, Middle, Last George Lester Wig | , | | | | 18. Mother's Nan | | | | |
| Maryland | s 1 end 2 should be filed within f Haalth end Mentei Hygiene. Item 27 is marked other than other traumatic event, the Ma | 2 | | | | 10h Mailie | Addrona (Stee | Haze et end Number or Ru | | abeth | | |
| ≥ S | 2 6 8 | | 19a Informant's Name/Relationship Narth Wiggleswort | h/wife | | | | urt, Seven | | | | Code) |
| e, | other tr | | 20a. Method of Disposition | | 20b. Pla | ice of Dispo | sition (Neme of netary or other p | | Date | 20c. Location - | 1146 City or To | wn, State |
| E | | | 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special | | | | ematory | noca) | Aug 16 | Baltim | ore. | MD |
| Baltimore, | permit. Page Department of important: If any injury or once. | | 21. Signature of Edneral Service Line | 1500 | 1 | | . Name and Add | | | | | |
| 0 | 88258 | | Vitt (| Same | - | Bar | ranco 8 | Sons, P. | A. Sever | na Park | Fune | eral Home |
| | | | 23a. Part. Enter the disease, or control of the con | plications that cause one cause on each li | d the death. | Do not ent | er the mode of d | lying, such as cardiac | or respiratory arm | rna Par | k, MI | Approximate Interval Between |
| d | Physician | | U | | | | | | | | 1 | Onset and Death |
| | /Medical Examiner | | Immediate Cause (Final disease or condition resulting in death) | · Ac | do | 515 | | | | | | 2 hours |
| | | -e | , | 41 | | as a conseq | | | | | - | 2 hours |
| | od dansit | Examiner | Sacratio II., list acceditions | b. 17 / | Due to for | as a conseq | mig | | | | 1 4 | Lhours |
| o, | an an | | Sequentially list conditions, if any, leading to immediate cause. Entar Undarlying Cause (Disease or Injury | , | Duo to for | as a conseq | uonos on. | | | | | |
| 68760, | icata be executed physician and s the buriel-transit | edlcai | Cause (Disease or Injury that initiated events resulting in death) Last | C | Due to (or a | as a conseq | uenca of): | | | | | |
| 9 X | requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the buriel-transit | ≥ | | d | | | | | | | | |
| Box | attend for us | Physician/ | | U . | | | | | | | 1 | |
| o. | t tha de | ysic | Part II. Other aignificant conditions of | | | _ | | given in Part I. | | | | the cause of death? |
| 0 | as that the | by Pf | Ventricular | Tibrila | tiun | 191 | rest | | 1 U Y | es EXNo | 3 Prol | bebly 4 Unknown |
| Records, | v requiras been sig should b | ed b | | | | | | | 24a. Was a | | 24b. We | ere autopsy findings ailable prior to |
| ဝင္ပ | 2 s | Completed | | | | | | | perform | ned / | CO | mplation of causa death? |
| R | 0 - 2 | Com | | | | | | | 1 🗆 Ye | s No | 1 [| Yes No |
| Vital | ician: The certificate rector, pag | Be (| 25. Was case referred to medical examiner? | | | | | 26. Place of Dea | th (Check only on | (0) | | |
| of | Physician: this certific ral director, | 10 | 1 ☐ Yes 2 No | Hospital: Inpatio | | R/Outpatien | A SEL DOA | | oma 5 🗆 Reside | | | 1) |
| | After funer | ion | 27. Manner of Death 1 Natural 5 ☐ Pending | 28a. Date of Inju (Month, Da | y Year) 2 | 28b. Time of Injury | 28c. In W | | 28d. Describe ho | ow Injury occur | red | |
| Division | deati deati tor: / the | flcat | 2 Accident invastigatio 3 Suicide 6 Could not b | e one Place of la | ury - At hom | ne farm str | | ☐ Yes 2 ☐ No | 28f. Location (Si | reet and Numb | er or Rum | I Route Number |
| S | or A efter Direct of in by | Certification: | 4 ☐ Homicide determined | building, et | c. (Specify) | 10, 14111, 011 | oot, suotory, ome | | City or Town | n, Stete) | | , |
| | To the Hospital within 24 hours e To the Funeral i completely filled | | 29a. Certifier Certifying Ph | ysician: To the best | of my knowl | edge, death | occurred at the | time, date and placa, | and due to the ca | ause(s) and ma | nner as si | ated. |
| | the Ho in 24 the Fu | edicai | one) | and manner st | ated. | on and/or inv | estigation, in my | y opinion, death occur | red at the lime, d | ate and placa, | and due to | the cause(s) |
| | To | Σ | 29b. Signature and title of certifier |) 1 | | MD | | nse number | | 9d. Date signe | | |
| | | ij | ruth | serg | | 10, | K | EJUUX | vy 1 | tugust, | /) | 1947 |
| | | | 30. Name and address of person who | completed cause of d | leath (Item 2 | 23a) (Type, | Print) | Baltimo | IC MI | , (KE | 、ナム | 1997 Dunleau |
| | Sta | te | 31. Date filed (Month, Day, Yeer) | | ar's Signatu | | , , | | | , , | | |



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|---|----|---|---|---|
| 4 | 1 | 6 | U | O |

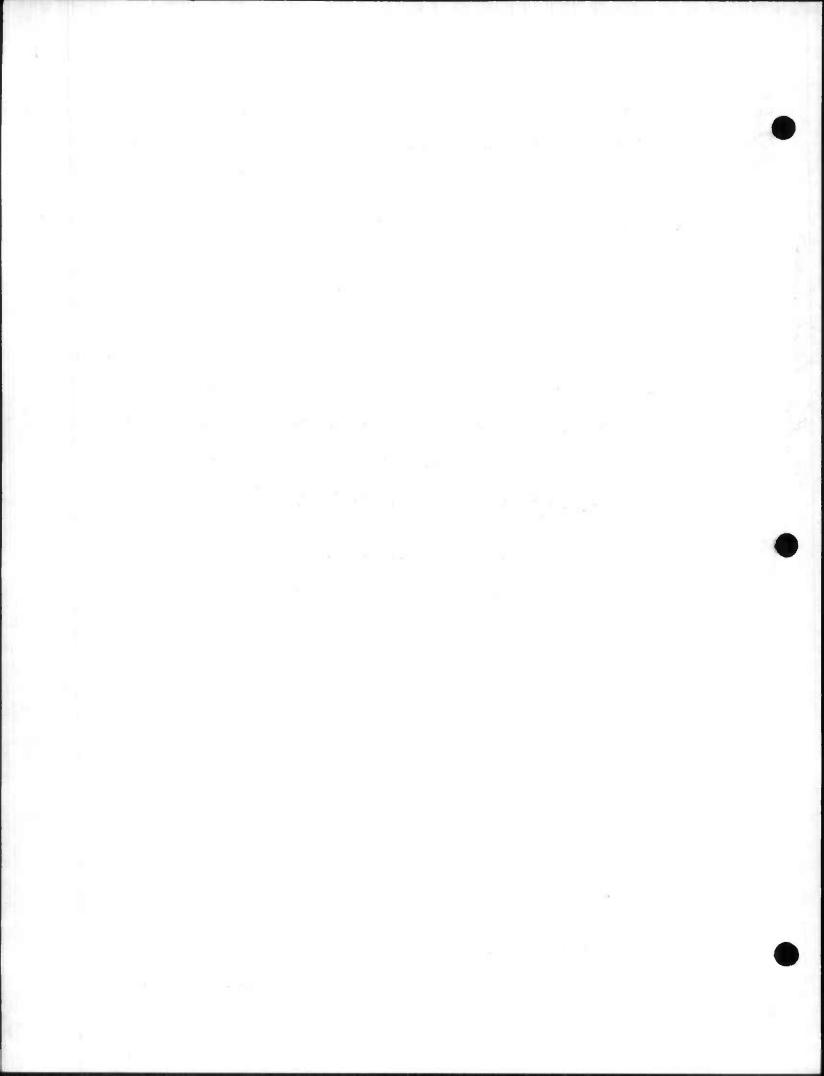
| | | | | | | | Cei | tificate of | | R | g. No. | , | - 1200 | | | |
|------------|--|------------------|--|---|--|----------------------------|---|---|---|---|---|---------------------------|---|--|--|--|
| | Dharain | | 1. Decedeni'a Nam | | st) | | | | | 2. Dete of Deat | h Dey | Year | 3. Time of Deeth | | | |
| | Physic /Medi | | Mildre | d Li | nda | Warı | ringt | on | | August | | 97 | 6:30 AM | | | |
| | Examir | | | | e street end number) | | | | 4b. City, Town, or | Location of Death | 4c. County | of Death | | | | |
| | | | | | Care - T | ne Pi | ines | | East | | | lbot | | | | |
| ۱ | Funeral Director | | 5. Social Security N 218-24- | 4431 | ex 7. Ag □M 2☐ME | e (In yrs. Ia 73 | st birthdey) Yrs. | If Under 1 Yeer Months Deys | | | 1923 | 9. Birthpl Coun MAR | ace (Stete or Foreign try) YLAND | | | |
| | work | ا | Usuel Residence of 10a. State | 10b. County | - | 10c. City, | Town or Lo | cation | | | | 10 | Od. inside City Limits | | | |
| | e Me | cto | MD | TA | LBOT | | EA | STON | | | | | XXYes 2□No | | | |
| | th with th | Funeral Director | 10e. Street and Nur 1020 | | INGTON S | r., ‡ | 902 | 10f. Zip Code 216(| 01 | 1 | 0g. Citizen of V U | Whet Coun | try? | | | |
| 020 | within 72 hours after deeth with the Meryland ene. than "natural", or items 23s or 28s-f show he Medical Examinet must be notified at | þ | 11. Meritel Statua 1 □ Never Marri 3 ➡ Widowed | ied 2 Merrled | 12. Was Decedent Armed Forces? 1 ☐ Yes X X I If Yes, Give Year or Dates: | | | Vas Decedent of I i Yes, specify Cub | | Specify Yes or No- to Rican, etc.) | 14. Race - American India Black, White, etc. Specify: WHITE | | etc. | | | |
| 21215-0020 | d within 72 hours affiliene. r than "natural", or the Medical Exam | Completed | | 15. Decedent's Ed | de completed) | | 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | | | | 16b. Kind of Bu | usiness/Ind | lustry | | | |
| 212 | | E | Elementery/Seco | ndary (0-12) | College (1-4or 5 | +) | | OUSEWIE | | | OLIDI | HOME | | | | |
| | E TE | Be C | 17. Father's Name | (First, Middle, Last) | | | 11 | OOSEMIL | | me (First, Middle, M | OWN feiden Sumem | | | | | |
| <u>a</u> | 2 2 2 9 | ToB | JAMES | A. ALL | EN | | | | | BLANCHE | CANNO | N | | | | |
| Maryland | d 2 should be h and Mental 7 is marked o traumatic ev | | 19a. Informant's Ne | ame/Relationship (| Type, Print) | | 19b. Mellin | g Address (Street | | ural Route Number | | | Code) | | | |
| | PENE | | LINDA | GUYTON | / DAUGHT | ER | 1200 | S. WAS | SHINGTO | N ST., AF | T.140 | 7, EA | STON, MD | | | |
| ore | ges 1 en it of Heai if Nem 2 or other | | 20e. Method of Disp | | Removel from State | cer | netery, cren | sition (Name of netory or other ple | | | 20c. Location - | | | | | |
| E | Pages ment of I ant: If Its lury or o | | SPRING HILL CEMETERY 8-27-97 EASTON, MD | | | | | | | | | | | | | |
| Baltimore, | pemit. Pag Department Important: I any Injury c | | 21. Signature of Juneral Service Loansee 22. Name end Address of Fecility FELLOWS, HELFENBEIN & NEWNAM FUNERAL 200 S. HARRISON ST., EASTON, MD 21601 | | | | | | | | | | | | | |
| | Physician | W. 1 | 23. Part1. Enter the shock, or hear | ne disease, or com rt failure. List only | plications that caused one cause on each lin | the death. | Do not ente | er the mode of dyl | Ing, auch as cardie | c or respiretory arre | est, | | Approximate Interval Between Onsel and Deeth | | | |
| | /Medical Examiner | | Immediate Cause (disease or condition resulting in death) | Finel n | | | y ec | lema | | | | 1 | 24 hous. | | | |
| | D ≃ | iner | | _ | . Ahr. (| ANG | OR | mote | stases | lumphn | odes | 1 | nontho | | | |
| | tificete be executed ig physician and es the bunal-transit | Examiner | Sequentially list con | nditions, | Quarrous cell | Due to (or a | as e conseq | uence of): | | 717 | | | | | | |
| 60, | be ex cian burial | al E | Sequentially list confit any, leading to Imcause. Enter Under Cause (Disease or that initiated events | rlying | · HM | | | | | | | 1 7 | years | | | |
| 68760, | physi the | edicai | that initiated events resulting in deeth) t | ast | | Due lo (or a | as a consequ | uenca of): | | | | | 1 | | | |
| | E 00 | | | | d | | | | | | | i_ | | | | |
| Вох | atten | cian | | | | | | | | | | | | | | |
| P.0. | thet the deeth cer ed by the attendir deteched for use | Physician/N | Pert II. Other significant | Icant conditions of | ontributing to death bu | it not result | ing In the ur | iderlylng cause gi | ven in Part I. | | | | the cause of death? | | | |
| | thet hed by dete | | | | | | | | | 1/2 Y | s 2□No | 3∐ Prob | ably 4 ☐ Unknown | | | |
| Records, | The lew requires thet the deeth cer ate has been signed by the attendir page 2 should be deteched for use | Completed by | | | | | | | | 24a. Wes a | | ave | re autopsy findings illable prior to appletion of cause | | | |
| Re | The lew ate has page 2 | ршс | | | | | | | | 1 □ Ye | s 25 No | | leath?] Yes 2□ No | | | |
| ta | | 0 | 25. Was case refer | red to medical | | | | | 26 Place of Do | eth (Check only on | | 1 | TYES ZU NO | | | |
| of Vital | | To B | examiner? 1 ☐ Yes 2 ☐ | | Hospitel: 1 ☐ Inpatie | nt 2 🗆 Fi | R/Outpatien | t 3□ DOA Oti | har . d | Home 5 ☐ Reside | | er (Snecify | 1) | | | |
| o uo | Attending Physic death. cotor: After this by the funeral d | | 27. Manner of Death 1 Netural 2 Accident | | 28e. Dete of Injur (Month, De) | у 2 | 8b. Time of Injury | 28c. Inju Wo | | 28d. Describe ho | | | | | | |
| Division | or Attendil efter death. Director: A in by the fu | Certification: | 3 Sulcide 4 Homicide | 6 Could not be determined | 28e. Place of Injubuilding, etc | ry - At hom . (Specify) | ne, farm, sire | eet, factory, office | | 28f. Location (St. City or Town | | er or Rurai | Route Number, | | | |
| _ | To the Hospital or Attending I within 24 hours efter death. To the Funeral Director: After completely filled in by the funer | edicai C | 29a. Certifler (Check only one) | Certifying Ph | ysician: To the best of liner: On the basis of and manner ste | exeminetio | edge, death va and/or inv | occurred at the ti estigation, in my o | me, date and plac opinion, death occ | a, and due to the ca urred el the lime, da | use(s) and ma ale end place, | anner as stand due lo | ated. the cause(s) | | | |
| | To the within 2 To the comple | Me | 29b. Signature end | title of pertifier | | | | 29c. Licens | se number | 29 | d. Dete signe | d (Month, L | Dey, Year) | | | |
| | PSPO | | | Molle | e)011/ | | | Pela | 375 | | 8/2 | 7/9- | 1 | | | |
| | | | 30. Name and eddre | ess of person who | completed cause of de | eath (Item 2 | 3a) (Type. I | Print) | 1100 | | 0/2 | 11(7) | | | | |
| | | | | | mans La | | CASI | | 10 216 | 100 | | | | | | |
| | | | and a septimination of | | | | | | ~ | | | | | | | |

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene 27257

| | | | | Ce | ertificate of | Death | | Reg. No. | | |
|---------------------|------|--|---|------------------------|---|---|--|-------------------------------------|-------------------|--------------------------------------|
| | | 1. Decedent'a Name (First, Middle, Las | t) | | | | 2. Date of D | | | 3. Time of Dea |
| nysician | _ | Archie H. Wi | lliams | | | | Augus | Day 3 1 | Year | 2:00 |
| Medical | | la. Facility Name (If not Institution, give | | | | 4b. City, Town, o | r Location of Dea | | y of Death | 2:00 |
| kaminer | | The second secon | | 0 77 | | | | | | |
| | 4 | Memorial H | | | 44 | East | | | lbot | |
| eral | | 5. Social Security Number 6. Se | 7044 OF F | (In yrs. last birthda) | Months Days | | | ay, Year) | 9. Birthpl | ace (State or F |
| tor | 1 | 218-09-7930 | 88 | Yrs. | | | 02-23- | 1909 | Mary: | land |
| | - 1- | Usual Residence of Decedent | | 10- 07- T | | | | | | |
| | -1- | 10a. State 10b. County | | 10c. City, Town or I | Location | | | | 10 | Od. Inside City |
| by Funeral Director | 1 | Maryland Queen An | nes | Grasonv | ille | | | | | 1 Yes 2 |
| Director | | 10e. Street and Numbar | | | 10f. Zip Code | | | 10g. Citizen of | What Count | try? |
| 0 | | 814 Cemetery Ro | ad | | 21 | 638 | | USA | | |
| Funerai | 5 | 11. Marital Status | 12. Was Decedent Ev | er in IIS 13 | | | Specify Yes or N | | ce - America | an Indian |
| 5 | 1 | 1 Never Married 2 Married | Armed Forces? 1 ☐ Yes 24 No | 0,0. | Was Decedent of If Yes, specify Cu | | rto Rican, etc.) | Bis | ck, White, e | |
| by F | | 3 Widowed 4 □ Divorced | If Yes, Give | | 1□ Yes 2☐No | Specify: | | Speci | fy: DI | |
| | | | Year or Dates: | | | LOSSIII - | | | | ack |
| Completed | | 15. Decedent's Edi (Specify only highest grad | | (Giv | edent's Usual Occu re kind of work done | during most of w | orking | 16b. Kind of E | Business/Ind | lustry |
| jdu | - | Elementery/Secondary (0-12) | College (1-4or 5+) | life. | DO NOT use retir | ed) | - 1.20 | | | |
| Ņ | | 7th | | Gar | dener | | | Wye P | lanta | tion |
| Be | | 17. Father's Name (First, Middle, Last) | | | | 18. Mother's No | am <i>e (First, Middle</i> | e, Malden Suma | me) | |
| ToB | | John C. Williams | 1 | | | E11a | Smallwood | d | | |
| - | | 19a. Informant's Name/Reletionship (T | | 19b. Mai | iling Address (Stree | et end Number or I | Rural Route Numi | ber. City or Town | . State. Zin | Code) |
| | | Cynthia Bailey | (daughter) | | . Box 572 | | | | 660 | |
| | 1 | 20a. Method of Disposition | (dadgireer) | | | | Date | 20c. Location | | Ctata |
| | ľ | 1 Burial 2 □ Cremation 3 □ | Removal from State | cemetery, cr | position (Name of rematory or other pl | a <i>ce)</i> | Date | 200. Location | - City of To | WII, State |
| | | 4 ☐ Donation 5 ☐ Other (Specify, | | Bryan's | Cemetery | • | 8/30/97 | Grason | ville. | ,maryla |
| d | -7 | 21. Signature of Funeral Service Licen- | weet " | | 22. Name and Add | , | | | | |
| 8 | | | | | Bennie Sm | | | | 2160 | 1 |
| | + | 23a. Partt. Enter the disease, or comp | finations that caused th | | P.O. Box | | | | 2100 | Approximete |
| | | br heart feilure. List only of | ne cause on each line. | OBAIT. DY HOT & | ther the mode of dy | ing, such as cardi | ac or respiratory | arrest, | | Interval Betwee |
| an | | | | | | | 1 | | i | Oriset and De |
| al / | | Immediate Cause (Final disease or condition | a cordi | o resp | ira for | 7) 47 | rest | |] | |
| 120 | - 1 | resulting in deeth) | Di | ue to (or as a cons | equence of): | | | | | |
| ner P | | | 601 | 7-11 | Can | cer | | | | Smow |
| E | | Sequentially list conditions | 0. | ue to (or as a cons | | | | | | - |
| X | | Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury | | | oquotion oi). | | | | | |
| dicai Examir | H. | Cause (Disease or injury thet initiated events | C | | 0 | | | | | |
| /Medical Examiner | | resulting in death) Lest | Di | ue to (or as a conse | equerica or): | | | | | |
| /Me | | | d | | | | | | | |
| a | | | | | | | | | 1 | |
| by Physician | F | Pert II. Other significant conditions co | ntributing to death but | not resulting In the | underlying cause g | iven in Part I. | 23b. Did | l tobacco use co | ontribute to | the cause of |
| Ph. | | | | | | | 1 | Yes 2□ No | 3 Prob | ably 450 |
| by | | | | | | - | - | | | |
| | | | | | | | | s an autopsy | 24b. We | re autopsy fin |
| Completed | | | | | | | perl | ormed? | con | illable prior to appletion of cau |
| Сошр | | | | | | | | | | leath? |
| ပိ | | | | | | | 1 🗆 | Yes 2 No | 1 🗆 | Yes 2□N |
| To Be (| | 25. Was case referred to medical examiner? | | | | 26. Piace of D | eath (Check only | one) | | |
| 2 | | 1 Yes 2 XNo | Hospitei: 1 ☐ Inpatient | 2 ER/Outpati | ent 3 DOA | ther: 4 Nursing | Home 5 □ Res | idence 6 🗆 Ot | her (Specify |) |
| Ë | 2 | 27. Menner of Death | 28a. Date of Injury (Month, Day) | 28b. Time | | | 7 | how Injury occu | | |
| Certification: | | 1 Natural 5 Pending 2 Accident investigation | (Month, Day) | <i>rear)</i> Injury | | ork?]Yes 2∐No | | | | |
| flcation: | | 3 Suicide 6 Could not be | 28e, Place of Injun | - At home, farm | street, factory office | | 28f. Location | (Street and Num | ber or Rure | Route Number |
| T | | 4 Homicide | 28e. Placa of Injury building, etc. | (Specify) | | | | wn, State) | | |
| 2 | | | | | | | | | | |
| Medical Certifi | | (Check only 2 Medical Exam | sician: To the best of r iner: On the basis of e | xaminetion end/or l | eth occurred et the i investigation, in my | time, dete end pied opinion, death occ | ce, and due to the curred at the time | cause(s) and m , date and place, | anner as standard | ated. the cause(s) |
| 8 | | one) | and manner state | d. | | | | | | |
| Σ | 12 | 29b. Signature end title of certifier | | | | nse number | - | 29d. Date sign | | |
| | | aly | MD | | DOG | 5113 | | 8-2 | 4-9- | 7 |
| | | 30. Neme and address of person who c | | th (Itam 23s) /Time | a Print) | | | | | |
| | 1 | O.breye | | | - | F. J 1 | ah | aw-1 1 | 21620 | 2 |
| | | | | | e Street, | receral | spurg, M | aryland | 21034 | ۷. |
| State | 1 | 31. Date filed (Month, Day, Year) | 32. Registrar | s Signature | 50 0 | | | | | |
| strar | | AUG 2 9 19 | 9/ 19:00 | a Davidson | gandelle | | | | | |
| | _ | | 17 | | | | | | | |



State of Maryland / Department of Health and Mental Hygiene

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Funeral Director

the Maryland "natural", or Items 23a or 28a-f show deeth filed within 72 hours aftar Shee ■ Baltimore, Maryland 21215-0020 Pages 1 and 2 should be filed within 72 honent of Heelth and Mental Hygiena.
Int: If item 27 is marked other than "naturary or other traumatic svent, in a Medical

Physician /Medical Examiner

sloian and burial-transit physician s the burial 88 USB ate has been signed by the a page 2 should be datached certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica funeral in by

The law requires that the death certificate be axecuted

Box 68760.

P.O.

Records.

Vital

Division of

Certificate of Death 1. Decedent's Neme (First, Middle Last) 2. Dete of Deeth Dev Voor Marie Wuckovich Jean 23, 1997 August 7:45 P.M. 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 10706 Rock Run Drive Potomac Montgomery If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) Deys 1□ M 2X F Yrs 217-42-1469 54 Oct. 27, 1942 Washington, DC Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No Maryland Montgomery Potomac 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 10706 Rock Run Drive Funeral 20854 United States 12. Wes Decedent Ever in U,S Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Yes 2√ No Specify: by 3€ Widowed 4 Divorced Specify: White Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Administrator Radiation Medicine 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Walter Gladding Marie McCatherine 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Anatoly Dritschilo 8101 Fenway Road, Bethesda, MD 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dete 1 ☐ Bunal 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Department of Important: If any Injury or once. Metropolitan Funeral Srv. 08/25/97 Alexandria, VA
22. Name and Address of Facility Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue, NW, Washington, DC 20016 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. proximete tervel Betw Onset end Deeth Immediete Ceuse (Finel Non Hodgkins Lymphoma 2 Years diseese or condition resulting in deeth) Due to (or es e consequence of): Examiner Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequença of) Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by Completed 24e. Wes en eutopsy performed? Were eutopsy findings eveilable prior to completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medica 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No 10 27. Magner of Deeth 28e. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury et Work? 1 Neturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 - Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner es stated.

[2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the cause(s) end manner steted. 29e. Certifie Medical (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Dey, Year) August 25, 1997 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Kenneth Miller, 18111 Prince Philip Dr. #327, Olney, MD 20832 32. Registrar's Signeture 31. Date filed (Month State Registrar

within 24 hours a complataly filled

To the

State of Maryland / Department of Health and Mental Hygiene 97 27250

| | | | | | | (| Certificat | e of | Death |) | F | eg. No. | | 41 | 239 |
|------------|--|----------------|---|--|----------------------|----------------------|----------------------------------|-----------------------|--|-----------------|---|---|-------------------------------------|---|----------------------|
| П | | | 1. Decedent's Neme (First, Middle, La | ist) | | | | | | | 2. Date of Dee | th | W. S. | 3. Tir | me of Casth |
| | Physic /Medi | | Sudie M. Wright | : (AKA | /Sue M | í. Wi | ight) | | | | Month August | 20, 1 | 997 | 11 | :00 A.M |
| D | Exami | | 4a. Fecility Neme (If not institution, given | e street end numi | ber) | | | | 4b. City, To | own, or Lo | ocation of Death | - | ty of Deeth | 1 | |
| 1 | | | 6409 Wiscasset F | Road | | | | | Bet | hesd | a |] | Montg | omer | У |
| Γ | Funeral Director | Γ | | Sex 7 1 □ M 2 □ (F | . Age (In yrs. 84 | last birth | Months | Deys | | 24 Hrs. Min. | 8. Date of Birth (Month, Dey Dec. 4 | Year) 1912 | Cou | ntrv) | tate or Foreign |
| | D. | | Usuel Residence of Decedent | | | | | | | | | | | | |
| | e Maryla le-f shov lifted et | Director | Maryland Montgom | nery | 10c. Cit | | or Location ethesda | | | | | | , | | Yes 2 No |
| | or 28 | Sire | 10e. Street end Number | | | | 10f. Zip | Code | | - | 1 | 0g. Citizen of | Whet Cou | ntry? | |
| | th w | | 6409 Wiscasset Ro | ad | | | | 208 | 316-21 | 14 | | Unite | ed Sta | ates | |
| 21215-0020 | 72 hours after death with the Maryland "naturel", or items 23a or 28a-f show solds! Examiner must be redified at | by Funeral | 11. Marital Status 1 Never Married 2 Married 3 Nowed 4 Divorced | 12. Wes Deced Armed Forc 1 Yes 2 If Yes, Give Year or Det | es? No | S. | | | Hispenic Ori pen, Mexicen Specify: | | ecify Yes or No- Rican, etc.) | 14. Ra Bl | ice - Americ eck, White, ify: | etc. | en, ite |
| 0 | 2 hor | Completed | 15. Decedent's E | ducetion | | 18e. D | ecedent's Usu | el Occu | petion | | | 16b. Kind of I | Business/In | | 200 |
| 215 | | pie | (Specify only highest green Elementary/Secondary (0-12) | ede completed) College (1-4 | lor 54) | (9 | Give kind of wo ife. DO NOT u | ork done se retire | during mos | t of work | ing | | | 30. | |
| 2 | filed within Hygiene. other than | E O | 11 | Conege (1- | 101 3+ <i>j</i> | | Bookk | eepe | er | | 1 | Mushro | om Dis | stri | butors |
| Maryland | be filed htal Hygie ed other event, it | Be | 17. Fether's Neme (First, Middle, Last, |) | | | | | 18. Mothe | er's Name | e (First, Middle, | Meiden Surne | me) | | |
| lai | should be ind Mental I | To | Heber Manni | .ng | | | | | В | essi | e Stokes | 3 | | | |
| an | and A | | 19e. Informent's Neme/Reletionship (| Type, Print) | | 19b. N | Meiling Address | (Stree | t end Numb | er or Rure | el Route Numbe | , City or Town | n, Stete, Zip | Code) | |
| Σ | s 1 and 2 should if Health and Mer item 27 is marks other traumatic | | Alice W. Waksmuns | ki/Daugh | ter | 640 | 9 Wisca | asse | t Roa | d. B | ethesda | Marv | and 3 | 2081 | 6-2114 |
| Baltimore, | es 1 and 2 of Health item 27 is r other tra | | 20a. Method of Disposition | | 20b. P | lece of D | Disposition (Ner | ne of | and. | | Dete | 20c. Location | - City or To | own, Ste | |
| E O | Pages nent of I int: If its iry or o | | 14 Surial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specif | | ate IIn i | on L | Iill Cer | not o | Aug. | 23, | 1997 I | Cennett | | | |
| | artm artm ortar | | 21. Signeture of Funerel Service Licer | | UIII | .011 1. | | | | ty Ro | bert A. | Pumph | sylvar | 11a | al Uama |
| B B | permit. Pages Department of Important: If is any injury or once. | | Michely G | Lutte | M0034 | 8 | Betheso | da-C | Chevy | Chas | e, Inc. 20814- | 7557 | Wisco | onsi | n Ave. |
| | | | 23a. Pert1. Enter the diseese, or com shock, or heart feilure. List only | plicetions that cau | sed the deet | n. Do no | | | | | | | | Approx | ximete el Between |
| ı | Physician | | , | | | | | | | | | | 1 | Onset | end Death |
| | /Medical | н | Immediate Cause (Finel diseese or condition | Meta | static | Bre | ast Car | ncer | • | | | | | 2 ye | arc |
| | Examiner | Ţ, | resulting in deeth) | θ | | | nsequence of): | | | | | | | . , . | |
| _ | 70 .E | ne | | | | | V (-,-) | | | | | | 1 | | |
| | cute | Examiner | Sequentially list conditions, | b | Due to (o | r es e co | nsequence of): | | | | | | | | |
| Ó | an a | | if eny, leading to immediate cause. Enter Underlying | | | | | | | | | | | | |
| 68760, | ysici be bu | ca | Ceuse (Diseese or Injury thet initiated events resulting In deeth) Lest | C | Due to (or | es e cor | nsequence of): | | | | | | | | |
| x 68 | aath certificate be executed attending physician and for use as the burial-transit | Medical | resulting in deetin) Lest | i. | | | | | | | | | į | | |
| 0 | th ce tendi | any | | d | | | | | | | | | 1 | | |
| Ö. | 0 0 0 | sici | Pert II. Other significant conditions of | ontributing to deat | h but not resu | ulting In th | he underlying o | euse gi | ven in Pert I | l. | 23b. Dld to | bacco use c | ontribute to | o the ca | use of death? |
| P. 0 | that the daath cert ed by the attendin detached for use | Physician | | | | | | | | | 1 🗆 Y | es 20X No | 3 Pro | bably | 4 Unknown |
| S, | | by F | | | | | | | | | | | | | |
| Record | E OD | Pa | | | | | | | | | 24e. Wes e | | 24b. W | ere euto eileble p | psy findings |
| 00 | s been | olet | | | - | | | | | | perfor | ned? | CO | mpletion deeth? | n of cause |
| | The law ata has b paga 2 s | Completed | | | | | | | | | 1 🗆 Ye | s 2XI No | | | oM No |
| Vital | | | 25. Was cese referred to medical | | | | | | 00 81 | | | | 1 | Yes | 2X No |
| | | To Be | exeminer? 1 ☐ Yes 2 🕅 No | Hospital: | etient O | ED/Out- | ations 2 DC | Ot | hor | | me 5 Reside | | | | |
| o | | | 27. Menner of Deeth | 28e. Date of | | ER/Outpo 28b. Tim | | /A | 4 🗆 140 | | me 543 Heside 28d. Describe ho | | | у) | |
| 0 | ding I h. After funer | tlor | 1 Meturel 5 Pending Investigation | | Dey Year) | Inju | ury M | 8c. Inju Wo | ork?]Yes 2□ | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | |
| 8 | Attending or death. | lica | 3 Suicide 6 Could not b | e con Dinner | Injuny - At ho | me farm | , street, fector | | ,,,,, | | 28f. Location (Si | reet and Nur | ther or Bure | al Route | Number |
| Division | | Certification: | 4 ☐ Homicide determined | | , etc. (Specify | | 1, 311001, 100101) | r, omce | | | City or Town | | Der Grand | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | rvaniosi, |
| _ | To the Hospital or Attentwithin 24 hours after deat To the Funeral Director: completaly filled in by the | edical C | 29a. Certifier 1 Certifying Ph | ystoten: To the be | est of my know | viedge, d | leeth occurred | et the ti | me, date en | d place, o | end due to the co | euse(s) end n | enner es s | tated. | ueo(e) |
| | the thin 2, the Ethe F | pe | one) | and manner | r stated. | . S. Gillore | | | | GOOGII | | | | | |
| | | Σ | 29b. Signature and title of pertifier | 1 0 | - Mari | / | 290 | . Licen | se number | | 2 | 29d. Date signed (Month, Dey, Year) | | | |
| | 10 | | Jahre | TSIT | 7/1 | | | D3 | 3554 | | August 20, 1997 | | | | |
| | | | 30. Name and address of person who | completed ause | of deeth (Item | 23a) (Ty | /pe, Print) | | | | | | | | |
| | | | John E. Yerg, II, | M.D., 5 | 401 We | ster | n Avenu | ie. | N.W | Wasl | hington, | DC 2 | 0015 | | |
| | Sta | ite | 31. Date filed (Month, Day, Year) AUG 2 6 | | | | -Rodell | | | | 0) | | | | |
| | Registr | - | AU6 2 6 | 199/ | guha Da | Mayor! | -Hondell | 6 | | | | | | | |

WRC 97-4726-027 WAYNE L. WILSON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

27260

| Physicia | n |
|----------|---|
| /Medica | |
| Examine | r |

Funera Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment must be matted as

Baltimore, Maryland 21215-0020

Physician /Medicai Examiner

To the Hospital or Attending Physician: The law requires thet the death certificeta be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completally filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760.

| | | | | | | Cen | tificat | e of | Death | | | Reg. N | io. | | | |
|-------------------------|--|-----------------------|------------------------|-----------------------------|---------------------|------------------|--------------------|-------------------|---------------------------|-----------------|---------------------------------|-------------|------------|-------------|-------------------------------------|----------|
| | 1. Decedant's Nam | a (First, Middl | la, Last) | | | | | | | | 2. Deta of De | | | | 3. Tima of D | eath |
| an | 7 | WAYNE | L. | WILS | TAC | | | | | | Month | | Day 1 O | Yaer | 2.02 1 | D8.4 |
| cal | - | | n, give street and nu | | 214 | | | | 4h Cihi To | um or l | AUGUST | - T | | | 2:02 I | PM. |
| ier | The second second second | | n, give street and no | imber) | | | | | | | | | c. County | | _ | |
| | RT. 10 |)8 | | | | | | | CO. | LUME | IA | | H | OWAR | D | |
| | 5. Social Sacurity N | lumbar | 6. Sex | 7. Aga (In | yrs. last bii | thday) | If Under Months | 1 Year Devs | If Undar Hours | 24 Hrs. Min. | 8. Data of Bir (Month, Da | th V Yes | (r) | 9. Birthp | olaca (State or F | Foreign |
| | 216-66-4 | 4216 | 1 □ M 2/2 F | 41 | | Yrs. | MOUTH | Deys | Hours | IVIII. | May 26 | 1.1 | 956 | Ma | rylan | d |
| | Usual Rasidanca of | | | | | | | | 4 . | | | | | | | |
| | 10e. State | 10b. County | | 100 | City, Tow | n or Loc | ation | | | | | | | 1 | 0d. Inside City | Limits |
| ō | MD | Но | ward | | Co | lum | bia | | | | | | | | Yas 2 | □ No |
| Sc | 10e. Street and Nu | | | | | | | 0.1 | | | | | | | | |
| 급 | | | | | | | 10f. Zip | | | | | 10g. C | | What Cour | 1 | |
| 70 | 5499 H | arper | s Farm I | Road, | #6 | | | 210 |)44 | | | | U. | S.A. | • | |
| Funeral Director | 11. Maritai Status | | 12. Wes Dad Armed F | | In U,S. | 13. W | as Dace | dant of I- | lispanic Ori | gin? (Sp | ecify Yas or No Rican, atc.) | - | | | en Indian, | |
| F | 1 Never Marr | ied 2 Mar | riad 1 ☐ Yas | 2 XNo | | | | | | i, ruanc | nican, atc.) | | | ck, Whita, | | |
| Completed by | 3 Widowad | 4 Divorced | If Yas, G Yeer or I | iva Datas: | | 1 | ☐ Yas | 2121 No | Specify: | | | | Specify | Bla | ACK | |
| g | | 15 Dacedan | it's Education | | 168 | Decada | ant's Usua | al Occur | ation | | | 16b | Kind of B | usinass/Inc | dustry | |
| iet | | cify only higha | st grada complated, | | | (Give k | and of wo | rk dona | ation during mos d) | t of work | ding | | | | 20011 | |
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| 2 | George | L. N | icholson | מ | | | | | Mi | ldr | red R. | Wi | lsor | 1 | | |
| | 19a. Informant's Ne | eme/Reletions | ship (Type, Print) | | 19b | . Meiling | g Addrass | s (Straat | and Numbe | er or Ru | ral Route Numb | er, City | or Town, | Stata, Zip | Code) | |
| | Mildred | R. J | ones (Mo | other |) 6 | 101 | Т111 | rnal | out. | Lar | ne, Col | 11m | bia. | MD | 21044 | |
| | 20a. Mathod of Disp | | | | Ob. Plece of cemata | | | | | | Date | | | - | own, State | |
| | | | 3 Ramoval from | Stata | | | | | | 1 | 1307 | | | | | |
| | 4 Donation | 5 Othar (S | (pecify) | H | opki | ns | Chu | rch | Cem. | | 3/27/9 | 7 | High | land | dM, E | |
| | 21. Signature of Fu | neral Service | Cydensee / | / | 7 | | | | ss of Facilit | | | _ | | | | |
| ٠. | 1000 | M4 11 | . Inns | w | Ou | | | | | | HOME, | Р. | Α. | | | |
| | 23s Part Fotori | le disease or | complications that | caused that | death Do | | | | E, MI | | 20850 | rraet | | | Approximate | - |
| | shock, or hos | rt failure. List | complications that | aach line. | | 101 01110 | | ou or uju | 19, 00011 00 | ourondo | or raspiratory a | 1001, | | | Intarval Batwe Onset and Da | en |
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| U | rasulting in death) | | α | | to (or es a | consequ | uanca of): | | | | | | | | | |
| Examiner | | | | | | | | | | | | | | 1 | | |
| Ē | Convention to that an | a state a s | b. — | Due | to (or es e | consequi | anna of). | | | | | | | | | _ |
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| b | resulting in deeth) I | Lest | | Dua 1 | to (or as a | consequ | ance of): | | | | | | | | | |
| Me | | | | | | | | | | | | | | į | | |
| | | | - 0. | | | | | | | | | | | | | |
| Physiclar | Part II. Other signif | tcant conditto | ons contributing to d | leath but no | rasulting in | n tha und | darlying c | ause giv | an in Part I | | 23b. Dld | tobacc | co use ço | ntribute to | the cause of | death? |
| ь | - | | | | | | | | | | 10 | Van | 2 No | 3□ Prol | bably 4 ☐ Ur | nknown |
| <u>ک</u> | | | | | | | | | | | | | 20110 | 0_110 | outly 4 day | IKIIQWII |
| Completed by | | | | | | | | | | | 24a. Was | on out | | 24h W | ara autopsy fine | dinac |
| e e | | | | | | | | | | | | rmed? | | av | allabla prior to mplation of cau | |
| ď | | | - | | | | | | | | | , | | | death? | 100 |
| ОП | | | | | | | | | | | 10 | Yes | 2□No | TNF | Yas 2 N | 0 |
| O | 25. Was casa refar | red to medica | | | | | | - | OO Disease | of David | th (Obsert sets) | - | | | | |
| o Be | examinar? | | Hospital: | | | | | Oth | or. | | h (Check only o | | 3.7 | | AT | |
| - | | | 10 | | 2 ER/O | | | JA | 4 🗆 140 | irsing Ho | oma 5 Resid | | | | SCEN | יבו |
| 0 | 27. Manner of Deatl 1 □ Naturel | n 5 ☐ Pendin | 28a. Date | of Injury oth, Day Yea | (r) | Tima of njury | 2 | 28c. Injur Wor | | / | 28d. Describe | | | | | |
| at | 2 Accident | invasti | gation | 219- | 1 1 | 402 | .PM | 1 🗆 | Yas 2 | No | MAINER | O | coa | , IMP | ACTWITH | -Rore |
| Ĕ | 3 ☐ Suicida 4 ☐ Homicide | 6 ∐ Could i datarm | inad 288. Placi | a of tnjury - ing, etc. (Sp | At homa, fa | rm, stra | at, factor | y, offica | | | 28f. Location (| Straat | and Numb | er or Rura | i Route Numbe | or, |
| je i | - L Tomoido | | Dullo | | 3 me | 2 | | | | | | | VARD | (D. | KUD | |
| 8 | 29a. Cartifiar | 1☐ Certifyin | g Physician: To the | 4 | | , | occurred | at the tir | ne, dete en | d place | | - | | | teted. | |
| Medical Certification: | (Check only one) | XXMedical | Examinar: On the b | asis of axer | nInation an | d/or Inva | astigation | , In my o | pinion, dee | th occur | red et the time, | date a | nd place, | and dua to | tha cause(s) | |
| ě | | title of section- | | | | | 00- | o Licero | a aumbar | | T | 204 5 | Note class | d /klonth | Day Vead | |
| | 29b. Signatura end | utie of certifia | n 111 | 0 - | | | 290 | | a number | | | | | | Day, Yaar) | |
| | > /U M | Morre | meuk | vll. | | | | 0. | .C.M.E | ≟. | | AUG | UST 2 | 22, 1 | 997 | |
| | 30. Nama and addr | ass of parson | who completed cau | se of death | (Itam 23e) | (Type P | rint) | | | _ | | | | | | |
| | MAMUNY | 1440 | h . 1/102- | | | | | | D-7: | L 4 | | | | 201 | | |
| | 31. Data filed (Mont | LI LUV | 17.100.0 | | | | | | , pall | глию | re, Mar | ута | IKI Z. | LZUI | | |
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State Registrar

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State of Maryland / Department of Health and Mental Hygiene 97 Certificate of Death

| Physician |
|-----------|
| /Medical |
| Examiner |

Funeral Director

the Maryla r 28a-f show r than "natural", or items 23s or the Medical Examiner must be n filed within 72 hours after Hygiens. ther then "natural", or he

2 should be fill and Mental H is marked off parmit. Pages 1 and 2 st Department of Health and Important: If them 27 is in any injury or other traun once.

Baltimore, Maryland 21215-0020

Box 68760.

Division of Vital Records, P.O.

Physician /Medical Examiner

physician and s the burial-transit the certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director;

Be

Certification:

edical

1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year Betty Barendsen Crummel Wilson 4e. Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO | If Under 1 Year | If Under 24 Hrs. | S. Dete of Birth (Month, Day, Year) | 9. Birthplace (Month, Day, Year) | 1924 | Indiana 5 Social Security Number 7. Age (In yrs. lest birthdey) 72 9. Birthplace (Steta or Foreign 1□ M 201 F 364-26-4060 Usuel Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Bethesda 1⊠ Yas 2□ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 20816 6300 Massachusetts Avenue Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 ☐ Never Merried 2 🕅 Married White 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation

16a. bind of work done during most of working Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done du life. DO NOT use retired) Elementery/Secondery (0-12) Coilege (1-4or 5+) Medical Medical Transcription 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) 8 Leora Stauffer Alban Barendsen 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 6300 Mass. Ave. Bethesda, MD 20816 Meredith Wilson Husband 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removei from Stete 8/28/97 Alexandria, VA 4 ☐ Donetion 5 ☐ Other (Specify) Mount Comfort Crematory 22. Name and Address of Facility
Joseph Gawler's Sons, Inc. 5130 WI Avenue, N.W. 21. Signature of Funeral Service Licensee ews Washington, D.C. 20016 . Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart leilure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Fine) Acute Myocardial Interction diseese or condition resulting in deeth) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that intlieted events resulting in deeth) Lest Due to (or es a consequence of): Physician/Medical Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to Completed 24e. Was an autopsy performed? 10

| | | | | 1 ☐ Yes 2 ☐ No | of death? | |
|---|--|--|---|---|--|--|
| 25. Wes case referred to medicat | | | 26. Place of Dec | eth (Check only one) | | |
| exeminer? | Hospitel: 1 inpatient 2 | ER/Outpatient 3□ D | me 5 Residence 6 Other (Specify) | | | |
| 27. Menner of Deeth 1 Neturel 5 Pending 2 Accident Investig | | 28b. Time of Injury M | 28c. Injury et Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how injury occurre | d | |
| 3 Suicide 6 Could n 4 Homicide determi | | ome, Ierm, street, lecto | ry, office | 28I. Location (Street and Number City or Town, State) | r or Rural Route Number, | |
| 29a. Certifier (Check only one) Certifying Certifying Certifying | Physician: To the best of my kno xaminer: On the basis of examine | owledge, deeth occurred ation end/or investigetio | d at the time, dete and plece n, In my opinion, deeth occu | , and due to the cause(s) and man rred et the time, dete end piece, er | ner as stated. nd due to the cause(s) | |

29c. License number

29d. Dete signed (Month, Dey, Year)

| Sta | ate |
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| | |
| Regist | rar |

31. Dete filed (Month, Day, Year) AUG 2 9 1997

W

29b. Signeture and title of certifier

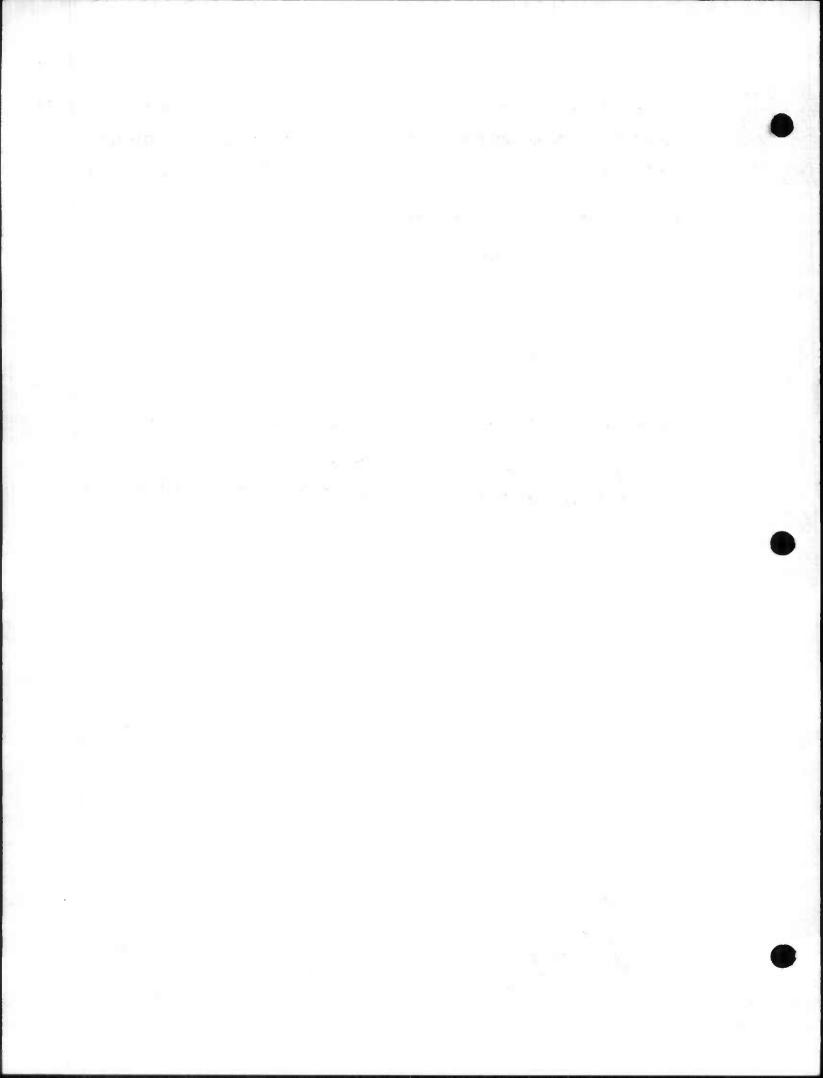
beeth (Hem 23a) (Type, Print)
560 Riverside de BIOT Salisbury, Md 32. Registrer's Signeture

and address of person who completed cause of deeth (Item 23a) (Type, Print)

Dieland

DHMH 16 Rev 6/95

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| | | | | | Cei | rtificate d | of Death | | Re | g. No. | | | | |
|--|--|---|---|---|---|-----------------------------------|------------------------------------|------------|------------------|---|--------------------------|---------------------------------------|--|--|
| | _ | 1. Decedent's Name (First, Middle, La | ast) | | | | | 2 | 2. Date of Deat | h | Van | 3. Time of Death | | |
| Physician Medical/ | _ | JAMES | G. WAT | KINS | | | | | AUG. | 26. 1 | Year 997 | 6:45 A | | |
| Examiner | _ | le. Facility Neme (If not institution, gi | ve street and number, | | | | 4b. City, Tow | | ation of Death | 4c. County | | | | |
| | ı | MARINER HEAD | LTH NURSIN | G HOME | | | SILVER | RSPR | ING | Mo | NTGO | MERY | | |
| uneral | | | | ge (In yrs. last b | | If Under 1 Ye Months Da | | 4 Hrs. 8 | Date of Birth | Year) | 9. Birthp | lace (State or Forei | | |
| rector | | | | | | | | | | | YLAND | | | |
| Mou W | 10a. Stete 10b. County 10c. City, Town or Location | | | | | | | | | | 1 | 0d. Inside City Limi | | |
| and in | 2 | MD MONTGO | MERY | | WHE | EATON | | | | | | 1 XYes 2 □ N | | |
| or 28a-f e be notified Director | | Oe. Street and Number | | 10 | Og. Ciflzen of V | Vhat Cour | itry? | | | | | | | |
| 234 2 | | 2615 BLUERI | 20902 | | | II | S.A. | | | | | | | |
| r Items 234 | | 11. Maritel Status 12. Was Decedent Ever in U,S. Armed Forces? | | | | Was Decedent | of Hispanic Origi | In? (Speci | ty Yes or No- | 14. Reci | e - Americ | an Indisn, | | |
| "netural, or items 23a or 28a-f show adical Examination must be notified at letted by Funeral Director | | 1 Never Married 2 Married 3 ₩ Widowed 4 Divorced | 1 Yes 2 If Yes, Give | | | r Yes, specify C | uban, Mexican, | Риепо н | can, etc.) | Specify | k, White, | etc. HIVE | | |
| ed salur | | 15. Decedent's E | ducation | 16 | e. Deced | ient's Usuat Oc | cupation | | 1 | 16b. Kind of Bu | | | | |
| | 1 | (Specify only highest gr Elementary/Secondary (0-12) | (Give | kind of work do DO NOT use rei | ne during most (lired) | of working | | | | | | | | |
| ura ura | 5 | 12 | College (1-4or | 0+) | | EXTERM | INATOR | | | EXTE | RMTN | ATING | | |
| avent, I | | 17. Fether's Name (First, Middle, Last |) | | | | | 's Name (i | First, Middle, M | faiden Sumam | | 12.2.10 | | |
| D 8 1 | 3 | JOHN NORM | AN WA | TKINS | | | | v | AIVI | R. | WATT | PRS | | |
| 7 is marks traumatic To | | 19a. Informant's Name/Retationship | | | b. Mailin | ng Address (Str | eet and Number | | | | | | | |
| 27 la | | MARY V. BAIN | /FRIEND | | SAN | | | #10 | | | | | | |
| other 2 | 2 | Oa. Method of Disposition | | | of Dispo | sition (Name of | | - | Date 2 | 20c. Location - | City or To | wn, Stete | | |
| | | 1 Burial 2 Cremetion 3 5 4 Donation 5 Other (Speci | | | | natory or other | | | | - | | | | |
| any injury or | - | 21. Signature of Funeral Service Lice | | S CREMATORY R 22. Name and Address of Facility | | | | | KDALI | E, MD. | | | | |
| any le | | NIMINI | | Ø. | 22 | Ivalile ello Ao | oress or racinty | | | | | PRING, MD | | |
| sician edical miner | | immediate Cause (Final disease or condition resulting in death) | a. ACUT | L INFA | RCTION | | | | | 1 HR. | | | | |
| physician and street transit street transit street Examiner | | Sequentially list conditions, if any, leading to immediate | conseq | nsequence of): | | | | | | | | | | |
| | | ceuse, Enter Underlying Cause (Disease or Injury | | | | | | | | | | | | |
| s the bu | | that initiated events resulting in death) Last | conseq | nsequence of): | | | | | | | | | | |
| S . | | | d | | | | | | | | | | | |
| for u | | | | | | | | | | | | | | |
| S S | , , | Part II. Other significant conditions | contributing to death b | ut not resulting | in the ur | nderlying ceuse | given in Part I. | | | | | the cause of deat | | |
| | | | | | | | | | 1 □ Ye | s 2□No | 3 Prot | pably 4 Unkno | | |
| d by | | | | | | | | | 24a. Was ar | autopsy | 24b. We | ere autopsy findings | | |
| should should | | | | | | | | | perform | ned? | eva | allable prior to mpletion of cause | | |
| m Pes | | | | | | | | | | | | death? | | |
| rector, page | | | | | | | | | 1 □ Ye | s 200 No | 1[| Yes 2□ No | | |
| director, | | 25. Was cese referred to medical examiner? | Hospital: | | | | Othor | | Check only one | | | | | |
| | Ъ | 1 ☐ Yes 2 🔯 No 27. Manner of Death | 1 LI tripatie | | | I JU DOA | 4 M Nurs | | | nce 6 Othe | | v) | | |
| 6 7 1 | | - | (Month, Da | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No | | | | | d. Describe no | w injury occurr | ed | 28d. Describe how tnjury occurred | | |
| funeral funeral | | 1 Canal 5 Pending Investigatio | | | o, farm, street, factory, office 28f. Location (Street and Number or Rural F City or Town, State) | | | | | | | | | |
| in by the funeral | | 1 m . m m m m m m m m m m m m m m m m m | 28e. Place of Inj | ury - At home, t c. (Specify) | arm, stre | eet, factory, office | Ce | 28 | | | er or Rura | Route Number, | | |
| in by the funeral | | 2 Accident Investigation 3 Suicide 6 Could not be determined | 28e. Place of Inj | c. (Specify) of my knowledg | e, death | occurred at the | time, date and | place, en | City or Town | , State) use(s) and ma | nner es si | ated. | | |
| in by the funeral | | 2 Accident Investigation 3 Suicide Could not be determined 4 Homicide 29a. Certifier Check only Check only | 28e. Place of Inj building, et aysicisn: To the best miner: On the besis o | c. (Specify) of my knowledg | e, death | occurred at the restigation, in m | time, date and | place, en | City or Town | , State) use(s) and ma | nner es si and due to | ated. the cauae(s) | | |
| he Funeral Director: After the platety filled in by the funeral edical Certification: | | 2 Accident Suicide Could not be determined 29a. Certifier (Check only one) | 28e. Place of Inj building, et aysicisn: To the best miner: On the besis o | c. (Specify) of my knowledg | e, death | occurred at the restigation, in m | time, date and y opinion, death | place, en | City or Town | , State) use(s) and ma ite and place, a | nner es si | ated. the cauae(s) | | |

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150 To 150% 20 70 00 No. A THE WAY LIVE Carlotte and the control of the cont Not done to the state of the st AND THE PROPERTY OF THE PARTY O (all boots or general designation and the source of the gap groups of the gap of the source of the gap of the source of the gap of the source of the gap of the source of the gap of the source of the gap of the source of the gap of the source of the gap of the source of the gap of the source of the gap of the source of the gap of the source of the gap of the source of the gap of the

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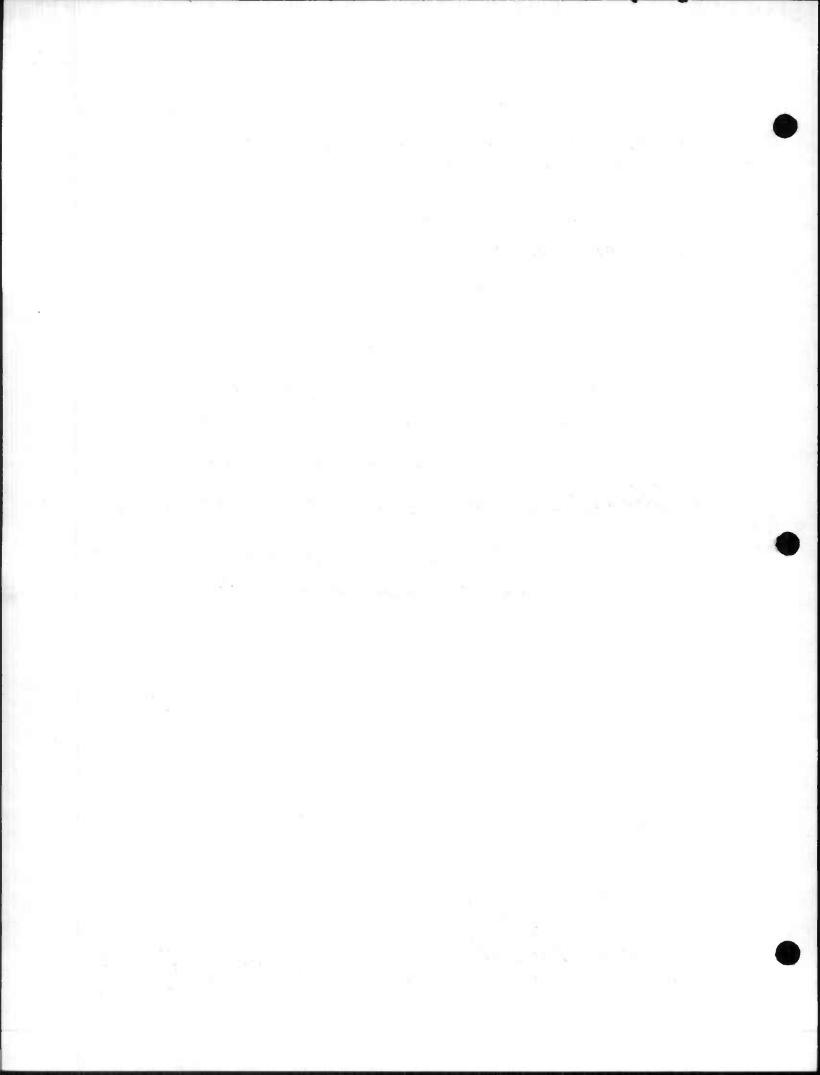
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 27263

| | | | | | | | Cer | tificate of | f Death | 7 | Re | g. No. | | - 1200 |
|------------|---|----------------|--|---------------------------------------|----------------------------|------------|-----------|---|----------------|------------------|---------------------------------|------------------|------------------------------|-------------------------------------|
| | | | 1. Decedent's Name (First, Midd | lle, Last) | | | | | | 2. | Dete of Death | h | | 3. Time of Death |
| | Physici | | Artis H. Wate | rs. Jr. | | | | | | Λ. | Month ugust 2 | Day ファ 100 | Year | 2.20 DM |
| S | /Medi Examii | | 4a. Facility Name (If not institution | | umber) | | | | 4b. City, To | own, or Locat | | 4c. County | | 2:20 PM |
| 7 | LAGITIII | IIGI | Mariner Healt | | | | | | 0.11 | 0 | | | | |
| - | Funeral | | 5. Social Security Number | 6. Sex | 7. Age (In) | | rthday) | If Under 1 Yea | SILVe | er Spr | Date of Birth | | gomer | aca (State or Foreign |
| | Funerai Director | | The second secon | 15xM 2□F | | | Yrs. | Months Day | | Min. | (Month, Day, | | | aca (Stata or Foreign try) |
| | | | 579-20-9216 Usual Residence of Decedent | | 72 | | | | | 100 | ct. 6, | 1924 | Washi | ington, D.C. |
| | de de | | 10a. State 10b. County | , | 10c. | City, Tow | n or Loc | ation | | | | | 10 | Od. fnside City Limits |
| | Mary 4 sh | ō | Manual and Manta | | | 0 * 3 | | Spring | | | | | | 1 ☐ Yas 2 ☑ No |
| | the 288 | Director | 10e. Street and Number | Maryland Montgomery | | | | | | | 10 | og. Citizan of ' | What Count | h. 2 |
| | death with the Maryland ma 23a or 28a-f show | | | | | | | | | | 10 | | | ary r |
| | eath m 23 | era | 10116 Renfrew | . 11.0 | 10.14 | | 0901 | deien sone st | N | U.S.A | | | | |
| | then the | Funeral | 1 Never Married 2 Mai | Armed F | | If Yes, sp | | as Decedent of Yes, specify Cu | ban, Mexice | n, Puerto Ric | an, etc.) | Bla | ce - America ck, White, e | an Inglan, etc. |
| 20 | hours efter tural', or ite | by F | 3 Widowed 4 Divorce | If Yes G | 2 □ No live | | 1 | ☐ Yes 2 🙀 No | o Specify | r: | | Specif | y: | |
| Ş | n 72 hours efter death with the Marylan "natural", or items 23s or 28s-f show edical Examiner must be notified at | | | 100101 | Wates. | WII | Doord | antia Harral Osar | | | | | Whi | |
| 21215-0020 | | Completed | (Specify only highe | nt's Educetion est grade completed |) | 104 | (Give I | ant's Usual Occi kind of work don O NOT use retir | a during mos | st of working | 1 | 6b. Kind of B | usinass/ind | ustry |
| 7 | filed withir Hygiene. other than | m m | Elementery/Secondery (0-12) | College | (1-4or 5+) | Ma | | | | | | 7 | | |
| 0 | Hygi ther | ŏ | 17. Father's Name (First, Middle | Last) | | Ma | rket | ing Man | - | er's Name /E | irst, Middla, M | | | ations |
| e a | od a b | Be | | , | | | | | TO. WOUL | ioi s idellio (r | irst, wildura, wi | aluen Suman | ne) | |
| 2 | should be nd Mental marked o | 2 | Artis Hamilto | | | | | | Anr | na Mago | delena | Smith | | |
| Maryland | N 0 9 8 | | 19e. informant's Name/Relation | | | | | g Address (Stree | | | | | | |
| _ | Beal P | | Patricia W. W | aters | 0.01 | 10 | 116 | Renfrew | Road | Silve | er Spri | ing, Mar | yland | 20901 |
| 0 | ges t of h if its | | 1 ☑ Burial 2 ☐ Cremation | 3 □Removal from | | cemete | ry, crem | atory or other pi | (ace) | | Date 2 | Oc. Location | - City or Tov | wn, Stata |
| | men ant: | | 4 Donation 5 Other (5 | Specify) | G | ate | of H | eaven C | emeter | cy 8/2 | 27/97 S | Silver | Sprin | g, Maryland |
| gaitimore, | permit. Peges 1 Department of H important: If itsi any injury or ot | | 21. Signature of Funeral Service | Licenson n | | | 22. | Name and Add | ress of Facili | ilv | | | | 3, |
| _ | ZOE Z O | | (teven) | Trond | | | | | | | | | | MD 20901 |
| | | | 23a. Part1. Enter the disease, o shock, or heert feilure. Lis- | complications that | caused the d | eath. Do | not ente | r the mode of dy | ying, such as | s cerdiac or re | espiratory arre | si, | | Approximate |
| ă. | Physician | | SHOOK, OF HOUR ISHUTE. LIS | | | | | na i cia | | | | | | Interval Between Onset and Death |
| 1 | /Medicai | | Immediate Cause (Final disaase or condition resulting in death) a. Chronie abstructure lung dexease ye | | | | | | | | | | | |
| | Examiner | | resulting in death) | a. | Due to | o (or as a | consequ | ience of): | ~ 1 | ung | acce | lone | - 7 | each |
| | | Je | | | 500 (| (01 45 4 | oonsaqt | orios orj. | | | | | 1 | |
| | certificete be executed ding physician and use es the buriel-transit | Examine | Conventinity list conditions | b | Due to | o (or as a | consequ | ience of): | | | | | | |
| ĵ | exection and an article. | | Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying | J | | (0. 40 4 | 00110040 | 01,00 | | | | | | |
| 09/90 | te be yslcië | edical | Cause (Disease or Injury that initiated events | (or as a | consequ | ence of): | | | | | | | | |
| g | ertifical ling phy e es th | ed | resulting in deeth) Last | | 200 10 | (01 03 0 | oorisequ | 01/0 | | | | | | |
| Š | ndin | n/M | | d | | | | | | | | | | |
| 0 | thet the death ce ed by the ettendi detached for use | Physician | Part II Other algoritics at acceptal | and contribution to | dandh budana | | - Ab | dad da consciona | Andria Dest | | ook Distant | | | |
|) | t the d | nys | Part II. Other algnificant condition | | 1 | | | | | '. / | | | | the cause of death? |
| _ | thet dete | V PI | Leaker | 4 lk | arec | ec | a | coury | AM | | 1 ∐ Ye | s 2∐ No | 3 ☐ Prob | ably 4 Unknown |
| cords | w requires that been signed to should be deta | d by | | | | | | | | | 24a. Was an | autonou | 24h Wei | re autopsy findings |
| Ŏ | | ete | | | | | | | | | perform | ed? | ava | llable prior to |
| ě | law hes t | Completed | | | | | | | | | | | | eath? |
| = | The le | CO | | | | | | | | | 1 ☐ Yas | s 211 No | 10 | Yes 2□ No |
| | Physician: The lav this certificate hes ral director, page 2 | Be | 25. Was cese referred to medical examiner? | | | | | | 26. Place | e of Death (C | heck only one |) | | |
| 5 | Physic this co | 2 | 1 ☐ Yas 2 ☐ No | Hospital: | Inpatient 2 | □ ER/O | utpatlent | 3□ DOA O | ther: 4 1 | ursing Homa | 5 Rasider | nce 8 Oth | er (Specify) |) |
| | fing Ph. After thi funeral | | 27. Manner of Deeth 1 ☐ Natural 5 ☐ Pendii | 28a. Date | of fnjury nth, Day Yeer | | Time of | 28c. Inju | ury at ork? | 28d | l. Describe how | w Injury occur | red | |
| IVISION | Attending or death. | atle | 2 ☐ Accident Invest | gation | | | | | Yes 2 | No | | | | |
| <u> </u> | or Attendent effer deat Director: | Certification: | 3 ☐ Sulcida 6 ☐ Could 4 ☐ Homicide determ | ined 288. Plac | e of Injury - A | | ırm, stre | et, factory, office | э | 28f. | Location (Street, City or Town, | | per or Rural | Route Number, |
| | s effe | Ce | | 3311 | mg, ore. (ope | U., y | | | | | ony or 7 onn, | 0.0.07 | | |
| | hour hour meri ly fill | | 29a. Certifier 1 Certifylic (Check only 2 Mertical | g Physician: To the | e best of my k | nowledge | , deeth | occurred at the t | time, date er | nd place, and | due to the car | use(s) end ma | anner as sta | ited. |
| | To the Hospital or At Within 24 hours efter of To the Funeral Direct completely filled in by | edical | one) 2 Medical | Examiner: On the bend man | nner stated. | netion en | d/or inve | estigetion, in my | opinion, dee | eth occurred a | at the time, de | te and place, | and due to | the ceuse(s) |
| | To the Hospital of within 24 hours of To the Funeral D completely filled in | Σ | 29b. Signature and title of certifie | // | // | | | 29c. Licer | nse number | | 29 | d. Date signe | d (Month, D | Day, Year) |
| | 0+1 | | > XXIII | Krock | LACIA | | | DO | 983 | 4 | | 8/25 | 797 | |
| 1 | _ | | 30. Name and eddress of person | who completed cau | ise of death // | em 23a) | (Type P | | | 1 | | 1 | , , | |
| | | | TRARRY ROS | SAIRA IIA | 4 | 子 つっ | () pa, r | FADON | 607 | ADI | - WE | 11.5111 | (17) | U, MD. |
| | Sta | te | 31. Date filed (Month, Add Page) | 7 1007 32.1 | Registrar's Sig | mature | - / | | | 2100 | , , , , , | 40 | 0,0 | 1 |
| | | | ATMAKE C | A PERMANENT | west else a | / la | 70 | inde se | | | | | | |

State of Maryland / Department of Health and Mental Hygiene 97 27261.

| -41 | | | | | , | Ce | rtificate | of L | | nomai riy | Reg. No. | 1 6 | . 1204 |
|-------------|---|---------------------|--|---|-------------------------------|----------------------------------|--|-----------------|---|--|--------------------------------|---|---|
| П | Physici | an | 1. Decedent's Neme (First, Midd | | | | | | | 2. Dete of Dec | eth Dey | Yeer | 3. Time of Death |
| J | /Medi | | MAURICE H. | WARS | AW | | | | | August | 01 20 | | 2:05 PM |
| ŀ | Examir | ner | 4e. Fecility Name (If not Institution | n, giva straat and number, |) | | | 4 | lb. City, Town, or L | ocation of Deeth | 4c. Count | y of Deeth | |
| L | _ 111 | | SPRINGBROOK AD | | | | | | ILVER SPE | | | GOMERY | 7 |
| į | Funeral Director | | 5. Sociel Security Number | 6. Sex 7. A | ge (In yrs. 86 | last birthday) Yrs. | If Under 1 \ Months D | rear Deys | If Under 24 Hrs. Hours Min. | 8. Dete of Birt (Month, Da) OCT • 14 | | 9. Birthpled Country POLAND | ce (Stata or Foreign v)) |
| | pue M. | | Usuel Residence of Decedent 10a. State 10b. County | , | 10c. Cit | y, Town or Lo | ocation | | | | | 100 | I. Inside City Limits |
| | Mary | ō | MARYLAND MONTG | OMERY | | ER SPF | | | | | | 1,00 | 1 ☐ Yes 2 ☐ No |
| | 288 P | rec | 10e. Street end Number | | | | 10f. Zip Co | ode | | | 10g. Citizen of | What Country | 17 |
| | h with | O I | 11442 LOCKWOOD | DRIVE #203 | | | 20904 | | | | UNITED | | |
| 020 | d within 72 hours efter death with the Maryland jiene. I than "natural", or items 23s or 28s-f show tribs Madcel Examiner must be notified as | by Funeral Director | 11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorce | | 7 No | | Was Deceden If Yes, specify 1☐ Yes 2√x | Cube | ispanic Origin? (Sp n, Mexican, Puerto Spacify: | pecify Yes or No- Rican, etc.) | Bie | ca - American ock, White, etc by: WHITE | C. |
| 5-0 | 72 ho | ted | 15. Deceder | nt's Education est grada complated) | | 16e. Dece | dent's Usuel C | ccupe | etion during most of work | (ing | 16b. Kind of B | lusiness/Indus | stry |
| 21215-0020 | iene. than | Completed | Elementary/Secondary (0-12) | College (1-4or | 5+) | TECHNI | DO NOT use r | ratired | idring most of work () | | DENTAL | | |
| | F F F | Be C | 17. Fether's Neme (First, Middla, | Last) | | 1 | | T | 18. Mother's Nem | e (First, Middla, | Maiden Surnar | na) | |
| lar | | ToB | SAMUEL WARSAW | | | | | | CLARA BOI | MAN | | | |
| Maryland | f Health and Mer them 27 is marke other traumatic | ' | 19e. Informent's Neme/Relations | ship (Type, Print) | | 19b. Mailir | ng Address (S | treet s | and Number or Ru | ral Route Numbe | r, City or Town | , Stata, Zip C | oda) |
| | and and T 27 | | BEATRICE WARSAW | /WIFE | | 1 | | | DR #203, | SILVER | SPRING | G, MD | 20904 |
| Ore | Peges 1 and neut of Hearnint: If item inty or other | | 20e. Method of Disposition 1 XBuriel 2 ☐ Cremetion | 3 □Removal from Stete | | Plece of Dispo emetary, crar | sition (Nama matory or othe | of r place | Θ) | Date | 20c. Location | - City or Towr | ı, Stete |
| altimore, | 2555 | | 4 Donetion 5 Other (5 | Specity) | | | MORIAL | | | 8/26/970 | DLNEY, | MARYLA | ND |
| Bal | Depariment Important Indiana | | 21. Signeture of Funerel Service | Licensee | , | | Neme end A | | ss of Fecility GOLDBERG | MEMORTA: | . CHAPE | T.S. TN | C |
| nim. | | < | 23a Part I Enter the disease of | a 17 | Se | e 11 | 70 ROC | KVI | LLE PIKE | . ROCKV | ILLE. M | ARYLAN | D 20852 |
| U | Dhualalan | | 23a. Pert1. Enter the disease, o shock, or heert feilure. List | only one cause on each l | d the deet ine. | n. Do not ent | er the mode o | t ayını | g, such es cardiec | or respiratory er | rest, | - In | pproximete nterval Between Onset end Deeth |
| | Physician /Medical | | Immediate Cause (Final | no | | ~ | / | | 111 | | | | |
| | Examiner | | disease or condition resulting in death) | · Cle | | r as a consec | nes | w, | Jaille | a | | 000 | |
| | p .= | iner | | arks | 11117 | Ches AX | derice or. | 6/ | Lever | relect | Dere | - 11 | 1 |
| | rtificate be executed ng physiclan and es the burief-transit | Examiner | Sequentielly list conditions, | 00000 | Due to (o | r es e conseq | juenca of): | | | 20-40 | | | |
| 60, | be ext | | Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury | | | | | | | | | | |
| 68760, | physi the t | edicai | thet initiated events resulting in deeth) Lest | | Due to (o | r es e conseq | uenca of): | | | | | | |
| ox e | 5 50 | 5 | | d | | | | | | | | | |
| ă | at at | Physician/ | | | | | | | | | | | |
| o. | that the de ed by the e detached i | hysi | Pert II. Other significant condition | ons contributing to death b | out not res | ulting In the u | nderlying caus | e give | en in Pert I. | | | | he cause of death? |
| ď, | es that igned b | by P | | | | | | | | 101 | res 2/2 No | 3 Probal | bly 4 Unknown |
| Records, | been s | Completed t | | | | | | | | 24a. Was perior | en eutopsy med? | aveila | autopsy findings able prior to pletion of cause |
| | 0 - 0 | mo. | | | | | | | | 1 🗆 Y | es 2 XNo | | res 2□ No |
| Vita | delan: The | Be C | 25. Wes case referred to medica | ı | | | | | 26. Place of Deel | | | | |
| | 5 00 | ToE | exeminer? 1 ☐ Yes 2 No | Hospitel: 1 ☐ Inpati | ent 2 | ER/Outpatien | nt 3 DOA | Othe | ar . | ome 5 Resid | | ner (Specify) | |
| 0 0 | ding Ph h. After th funeral | | 27. Manner of Death 1 ☐ Neturel 5 ☐ Pendir | 28e. Dete of Inju | lry ay Yaar) | 28b. Time of Injury | 28c. | Injury | et c? | 28d. Describe h | ow Injury occur | rred | |
| Sio | Attending r deeth. actor: After by the fune | cati | 2 ☐ Accident investi | getion | | | М | | Yes 2□No | | | | |
| Division of | of or Attended after deet I Director: | Certification: | 3 Suicide 4 Homloide 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number or Rur | | | | | | | | loute Number, | | |
| | To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune | edicai (| 29e. Certifier (Check only one) 1 Certifyir 2 Medical | ng Phyeician: To the best Examiner: On the basis of end manner st | of my kno examine ated. | wledge, deeth tion end/or inv | occurred et ti restigation, in | he tim my op | e, date end plece, pinion, deeth occur | end due to the or | cause(s) and modele end piece, | enner as stete and due to th | ed. e cause(s) |
| | withir To th comp | Me | 29b. Signeture and title of certifie | | | | | | namber / | | 29d. Date signe | | |
| | 13 | | Musen | Louis | en | _ | 00 | a | 0/4 | | 8/25 | 5/97 | , |
| | | | 30. Neme and address of person | | | | Print) 2 | 3 | 09 8 | HORE | E,420 | RO | |
| _ | | | MYROW L | LENK | IN | MD | h | 74 | EMTON) | NO | 200 | 200 | |

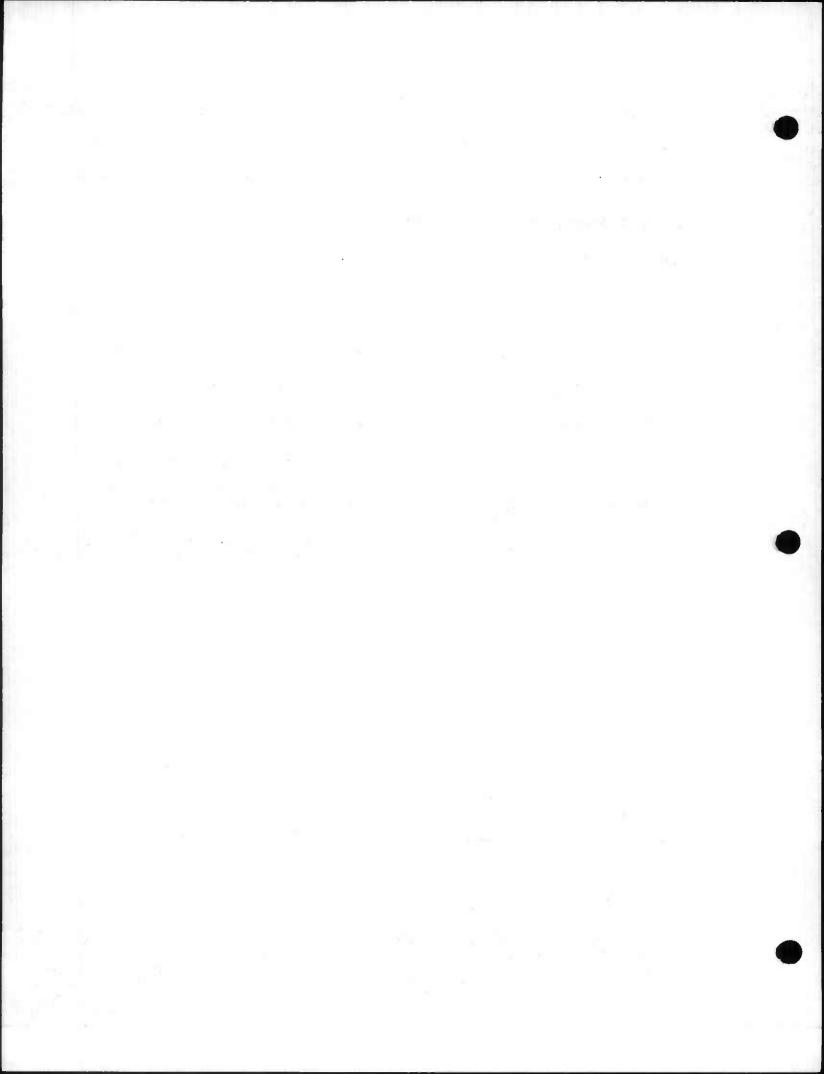
State Registrar



State of Maryland / Department of Health and Mental Hygiene

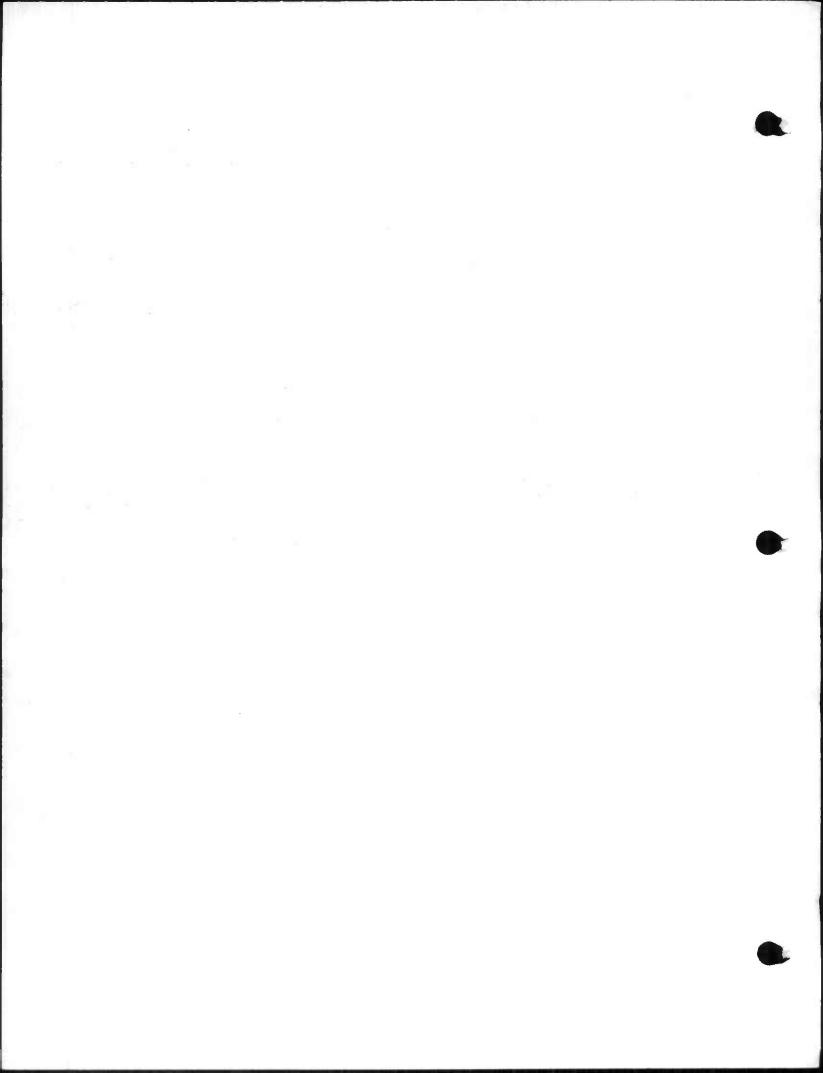
97 27265

| _ | | | | | | Cei | rtificate of | Death | | F | Reg. No. | | |
|---------------------|---|----------------|---|--|-------------------------------|-------------------------------|--|------------------------------|------------|---------------------------------|------------------------------|--------------------------------|---|
| | Discosta | | Decedent's Name (First, Middle | e, Last) | | | | | | 2. Date of Dea Month | | Year | 3. Time of Death |
| | Physic /Medi | | Dorothy Evely | n Walters | | | | | | August | 25. 1 | 997 | 0330 AM |
| | Exami | | 4a. Facility Name (If not institution | n, give street and nun | nber) | | | 4b. City, To | wn, or Lo | cation of Death | - | nty of Death | 0330 111 |
| 1 | | | Montgomery Gen | eral Hosp | ital | | | Olne | v | | Mon | tgomer | v |
| Н | Funeral | П | 5. Social Security Number | | 7. Age (In yrs. la | st birthday) | If Under 1 Year | If Under | 24 Hrs. | 8. Date of Birtl (Month, De) | | 0 | - |
| | Director | | 579-14-6298 | 1□ M 2및 F | 75 | Yrs. | Months Days | Hours | Min. | Month, Des | 7, <i>Year)</i> 1 9 2 1 | Mary1 | place (State or Foreign htry) |
| | | | Usual Residence of Decedent | | | _ | | | | 1011209 | 1/21 | process and | , carro |
| | Man Man | | 10a. State 10b. County | | 10c. City, | Town or Lo | cation | | | | | 1 | 0d. Inside City Limits |
| | Man | ō | Maryland Montg | omerv | Roo | ckvill | 9 | | | | | | 1 ☐ Yes 2 ☐ No |
| | tha 28s | Director | 10e. Street and Number | omery | 2.0 | | 10f. Zip Code | | | | 10g Citizen | of What Coun | ntry? |
| | With | | | D 1 | | | | - 2 | | | U.S. | | , |
| | within 72 hours after deeth with the Maryland ane. than "natural", or Nama 23a or 28a-f show he Medical Examinet must be notified at | Funeral | 4508 Aspen Hill | | dent Ever in U,S | 10.1 | 2085 | | -1-2 (0- | alf. Van au Ala | | Race - Americ | an Indian |
| | er d | S | 11. Marifal Status | Armed For | rces? | 13.1 | Was Decedent of f Yes, specify Cub | oan, Mexicar | n, Puerto | Rican, etc.) | 14. F | Black, Whife, | |
| 20 | s aft | by F | 1 Never Married 2 Marria 3 Widowed 4 Divorced | If Yes, Giv | 0 | | 1□ Yes 2√2 No | Specify: | | | Spe | city: | |
| Maryland 21215-0020 | natural', | | | Year or Da | ites: | | | | | | | Whi | |
| 7 | d within 72 he plane. | Completed | 15. Decedent (Specify only highest | t's Education of grade completed) | | (Give | dent's Usual Occu kind of work done | during mos | t of work | ing | 16b. Kind of | f Business/Inc | dustry |
| 2 | within ane. than | du | Elemantary/Secondary (0-12) | Collage (1 | -4or 5+) | | DO NOT use retire | , | | | | 77 | |
| 7 | 77 7 10 100 | S | | 1 | | H | Homemaker | | | | | 1 Home | |
| nd | be filed lel Hygi d other | Be | 17. Father's Name (First, Middle, | Last) | | | | | | (First, Middla, | | iame) | |
| Na Na | Man | 2 | Louis C. Schm | nidt | | | | Ma | ry M | . Griff | ith | | |
| a | d 2 should be filed to and Mantel Hyg. I is marked other traumatic event, | ľ | 19a. Informant's Name/Ralationsi | hlp (Type, Print) | | 19b. Mailin | ng Address (Stree | t end Numbe | er or Rura | al Route Numbe | r, City or To | wn, Stete, Zip | Coda) |
| | E = 8 F | | Charles E. Walt | ers | | 901 Wa | ide Aveni | ue Ro | ckvi | lle,Mar | yland | 20851 | |
| 9 | of Heel | | 20a. Method of Disposition | | 20b. Pla | ce of Dispo | sition (Name of | | | Date | 20c. Locatio | on - City or To | wn, State |
| 20 | Pegas nent of nt: If its | | 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (St | | otate | | netory or other ple | | | 8/28/97 Rockville, Maryland | | | 1 |
| Baltimore, | nit. Perantmen ortant: | | 21. Signature of Funeral Service I | | Par | | Memoria | | | /28/9/ | ROCKVI | TITE, M | aryland |
| Ba | permit. Pega Department of Important: If any Injury or once. | | 21. Olganitate of Furioral Service (| Licensee C | | | cancis J | | | Funeral | Home | , Inc. | |
| _ | | | Drewick | Looken | | 50 | 00 Unive | rsity | Blvd | .,W.,Si | lver S | Spring | ,MD 20901 |
| | | | 23a. Part 1. Enter the disease, or shock, of heart failure. List | complications that co | aused the death. ach line. | Do not ente | er the mode of dy | ing, such as | cardiac o | or respiratory are | rest, | , | Approximate Interval Between |
| | Physician | | Colored Colored To graph | | | | | | | | | | Ogsør ogd Dyfath |
| | /Medical | | Immediate Cause (Final diseasa or condition 1990 1990 1990 1990 1990 1990 1990 199 | | | | | | | | | | 481100V |
| п | Examiner | | resulting In death) | a | Due to (or | as a conseq | uance of): | 0.11 | 1 | | | | 1.00 |
| - | D = | ne | | | | | | | | | | | |
| | cartificate be assecuted ding physician and ise as the buriel-transit | Examiner | Sequentially list conditions. | 6 | Due to (or | as a conseq | uanca of): | | | | | | |
| ó | an an riel-t | M | Sequentially list conditions, if any, leading to immediate cause. Entar Undarlying Cause (Disease or Injury that initiated events | | | | | | | | | | |
| 68760, | ysici ysici | edical | that initiated events | c | Due to (or a | as a consequ | uence of): | | | | | | |
| 89 | g ph | b | resulting In death) Lasf | | | | | | | | | | |
| XO | | M/u | ' | d | | | | | | | | | |
| 0 | death a ette ed lor | Physicia | Part It. Other significant conditio | na contribution to do | ath hut and annul | ata a ta aba | ada da da a a sana a sana | han la Dani I | | non Dida | | | the causs of death? |
| 0 | the y the | ys | Tan II. Other algimicant conditio | THE CONTINUENTS TO GE | atti Dut Hot resul | ung in tile ur | nderlying cause gi | Well III Fall I | | | V | | |
| ٥ | requiras that the de been signed by tha e should be deteched I | | | | | | | | | 101 | 88 2/N | o 3 Prot | bably 4 ☐ Unknown |
| ds | 8 6 4 | d by | | | | | | | | Ode Wee | | 24b W | are sutoney findings |
| 0 | v require |) te | | | | | | | | 24a. Was a | med? | ave | ere autopsy findings allable prior to mpletion of cause |
| of Vital Records, | \$ 00 K | 힏 | | | | | | | | | | of c | death? |
| <u> </u> | 8 - 0 | Completed | | | | | | | | 1 🗆 Y | es 2 No | 10 | ☐Yes 2☐ No |
| ā | iclan: Th certificata rector, pag | 8 | 25. Was case referred to medical | | | | | 28. Place | of Death | Check only or | ne) | | |
| > | | To B | examiner? | Hospital: | patient 2 E | R/Outpatien | t 3 DOA Ot | har | | me 5 ☐ Resid | | Other (Specifi | (v) |
| | Physic this aral d | | 27. Manner of Death | 28a. Date o | f Injury 2 | 28b. Time of | | | | 28d. Describe h | | | 77 |
| o | ding l h. Aftar fune | to | Natural 5 Pending | | n, Dey Year) | Injury | | ork? ☐☐ | No | - | | - | |
| S | Attending or death. | Ica | 3 Suicide 6 □ Could n | ot be | of Injuny - At hon | ne form etr | aet, factory, office | | | 28f Location /S | treet end Nu | mber or Rura | Il Route Number, |
| Division | after death Director: | Certification: | 4 Homicide datami | buildin | g, atc. (Specify) | | aot, lactory, office | | | City or Tow | n, State) | | Troute runiber, |
| _ | To the Heepital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely lilled in by the funeral | - 1 | 20a Codillos | - Dh | | | | | | | | | |
| | Hospital 24 hours Funeral staty lilled | edical | 29a. Certifier (Check only one) 2 Medical E | g Physician: To tha i Examinar: On the be | sls of examination | iedge, death on and/or inv | estigation, in my | ime, data an opinion, dea | th occurr | ed at the time, o | euse(s) and date and plac | manner as st be, and due to | ated. the cause(s) |
| | To the within 2 To the comple | Me | - | and mann | ar stated. | | 3 00- 11 | | | | and Data ala | | O. Vara |
| | or ¥ or no | 7.7 | 29b. Signature and title of diritier | · /NJ | -// | MI | 29c. Licen | 1 - | 111 | 111 | Date sig | ned (Month, | Day, Tear) |
| | φ | | Man | 1000 | WU | 110) | 11/6 | 110 | 16 | 4171 | Tua | uno | 2,//// |
| | | | 30. Name analysis of persony | who domple ed cause | of death stem | 23a) (Type, | Print) | 12. | 7 / | - | 211. | 14201 | ala sori |
| | | | OTTUEY U | 1201 | VIJO | 1/ | Indi | 100 | 4/6 | 121 | Cluh | WOUNK | 115214 |
| | Sta | ite | 31. Date filed (Month 1997) | R 1007 32. Re | districts Similar | 10 50 | | | | | | 1 | m no |
| | Registr | ar | / | F 1001 | 1 which will | morr-Ma | Marie | | | | | M | 1/2/1/ |



| BALTIMORE, MARYLAND 21215-0020 | 24 hours after death. Page 6 may be retained by the hospital or attending physician. | is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. or Health and Mental Hygiene prior to burial, cremation, or removal. | he medical examiner must be actified at once. |
|---|--|--|---|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760 | TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-ref hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this cardificate has been signed by the attending physician and completely filled in by the fune be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT if item 28 is marked or item 23 shows any interest or other fraumatic event the medical available he notified at seen |

| | | | | 97 27266 | | | | | | |
|------------------|--|--|--|---|--|--|--|--|--|--|
| | 1 - FOR STATE OF MARYLAND / DEPAREGISTRAR CERTI | RTMENT OF HEALTH AND FICATE OF DEATH | MENTAL HYGIENI REG. NO. | E | | | | | | |
| | 1. DECEDENT'S NAME (EI'St, Middle, Last) JOHN VAVENE | ER | 2. DATE OF DEATH MONTH DA August 15, | 1997 YEAR 3. TIME OF OEATH 8:45 AM M | | | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 1 X M 2 F 8. AGE (In yrs. last birthde | / IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | June 23, 1 | 914 Connecticut | | | | | | |
| 10R | 9e. FACILITY NAME (# not Institution, give street end number) Hebrew Home of Greater Washington | 9b. CITY, TOWN OR LOCATION OF C | EATH | Montgomery County | | | | | | |
| DIRECTOR | | ITY, TOWN OR LOCATION Kensington | | 10d. INSIDE CITY LIMITS? | | | | | | |
| | 10e. STREET AND NUMBER The Groves, 3616 Littledale Road #10 | 10f. ZIP CODE | | tion citizen of what country? United States | | | | | | |
| BY FUNERAL | 11. MARITAL STATUS 1 Never Married 2 Merried 3 X Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPA If yes, specify Cuben, Maxic 1 YES 2 X NO Specify | an, Puerto Rican, etc.) | or No— 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | | |
| COMPLETED | (Specify only highest grade completed) (Give kind (Give kind title. Do NOT life. Do | S USUAL OCCUPATION If work done during most of working use relired.) ager | Food M. | | | | | | | |
| 111 | 17. FATHER'S NAME (First, Middle, Last) Barney Yavener | | AME (First, Middle, Melden S ca Shapiro | Surname) | | | | | | |
| 2 | | og ADDRESS (Street and Number or Rural O Fairclough Place | | | | | | | | |
| 110,211 06 | 20a, METHOD OF DISPOSITION 1 \(\text{\text{NB uriel}} \) 2 \(\text{\text{Cremation}} \) 3 \(\text{\text{\text{Removal from State}}} \) 20b. PLACE AND DATE OF DISPOSITION (Name of cappaiery, cremation, or other place) Cemetery 4 \(\text{\text{Donation}} \) 6 \(\text{\text{\text{Other (Specify)}}} \) 8-\(7 \) Clifton, New Jersey | | | | | | | | | |
| CYGHILLET | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE #M00690 | Louis Suburba | in Chapel | air Lawn, NJ 07416 | | | | | | |
| Achi, ine medica | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition as a subject of the consequence | | | | | | | | | |
| SERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| MEDICAL (| | | | | | | | | | |
| | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 22. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) | | | | | | | | | |
| PHYSICIAN: | 1 | OTTER: 4 Nursing Home 5 Residence ME OF VORK? M 1 YES 2 NO | 6 Other (Specify) 28d. DESCRIBE HOW IN | JURY OCCUREO | | | | | | |
| TED BY | 2 Accident Investigation 3 Suicide S Could not be determined City or Town, State) 28e. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, term, street, tectory, office City or Town, State) | | | | | | | | | |
| COMPLETE | 29e. CERTIFIER (Check only one) 1 CERTIFVING PHYSICIAN: To the best of my knowledge, death occur one) 2 MEDICAL EXAMINER: On the basis of exemination end/or investigation. | | | | | | | | | |
| TO BE | 29b. SHCHATURE AND TITLE OF CHITTEEN STAFF PHYSIC 30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (7) | 1 AN 29° LICENSE NUI | MBER USY | 29d. DATE SIGNED (Month, Day, Year) AUGUST 15,1997 | | | | | | |
| | 31. DATEL M.D. 6/21 MON" | TROSE RD ROC | kville, M | 1020852 | | | | | | |
| | AUG 21 1997 Stohia Davidson-Rand | | | | | | | | | |



State of Maryland / Department of Health and Mental Hygiene 27267 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Daeth 3. Time of Death Physician Month Abraham Zevin 25, 1997 4:45pm August /Medical 4a. Fecility Neme (If not institution, giva straat and numbar) 4b. City, Town, or Location of Daeth 4c. County of Death Examiner 5450 Whitley #502 Park Terrace Bethesda Montgomery If Under 1 Yaer If Undar 24 Hrs. 8. Dete of Birth (Month, Day, Year 6. Sex 1 🛣 M 2 🗆 F 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 76 578-24-0064 Yrs June 4,1921 Washington, DC Usuel Residence of Decedent 10e. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Director Maryland Montgomery Bethesda 10e. Street end Number 10f Zin Code 10g. Citizen of Whet Country? 5450 Whitley Park Terrace#502 20814 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Biack, White, etc. IXIYas 2□ No If Yes, Give Yaar or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grada completed) 16e. Dacedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Alexandria Elamantery/Sacondary (0-12) Collaga (1-4or 5+) Controller Scrap Corp. 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be Goldie Weinberg Max Zevin 19e. Informent's Name/Raletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5450 Whitley Park Terr. Bethesda, MD 20814 Elinor S. Zevin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Bunal 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) King David Mem. Gdns.8/27/97 Falls Church, VA 22. Neme and Address of Fecility

Ives-Pearson Funeral Homes 21. Signature of Funeral Service Lie 2847 Wilson Blvd. Arlington, 22201 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Batween Onset end Death lymphone montle Immediata Cause (Finel disaase or condition resulting in daath) Dua to (or es e consequance of): Examiner Sequentielly ilst conditions, if eny, leeding to immediata cause. Enter Underlying Cause (Disease or Injury that Initiated evants resulting in deeth) Lest Dua to (or es e consaquance of): Physician/Medical Due to (or es e consequenca of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24a. Was en eutopsy performed? 24b. Were eutopsy findings Completed available prior to complation of cause of deeth? 2 No 1 Yes 1 Tyas 2 No Be 25. Was case rafarred to medical exeminer? 26. Pleca of Deeth (Check only ona) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Othar: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending investigation 1 Neturel 2 Accident 1 Yes 2 No 6 ☐ Could not be determined 3 Sulcida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicida edical 1 Certifying Physician: To the best of my knowledge, daeth occurred et the time, dete end pleca, and due to the ceuse(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion end/or invastigetion, in my opinion, death occurred at the time, deta and place, and due to tha ceuse(s) end manner steted. 29e. Certifier 29b. Signature and title of certifier 29d. Dete signed (Month, Day, Year) 30. Name and eddrass of pereon who completed cause of deeth (Itam 23a) (Type, Print) Littl

atur ent

Columbia, Md 21044

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. Hospital or Attending Physician: **Funeral**

Director

28a-f show

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traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours efter death v Depertment of Health end Mentel Hygiene. Important: If Item 27 is marked other than "natural", or frems 23a and injury or other traumatic event, the Medical French 2002.

Physician

/Medical

Examiner

physicien and the buriel-transit

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page 2 hes

funeral director.

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After

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I Director: Aff

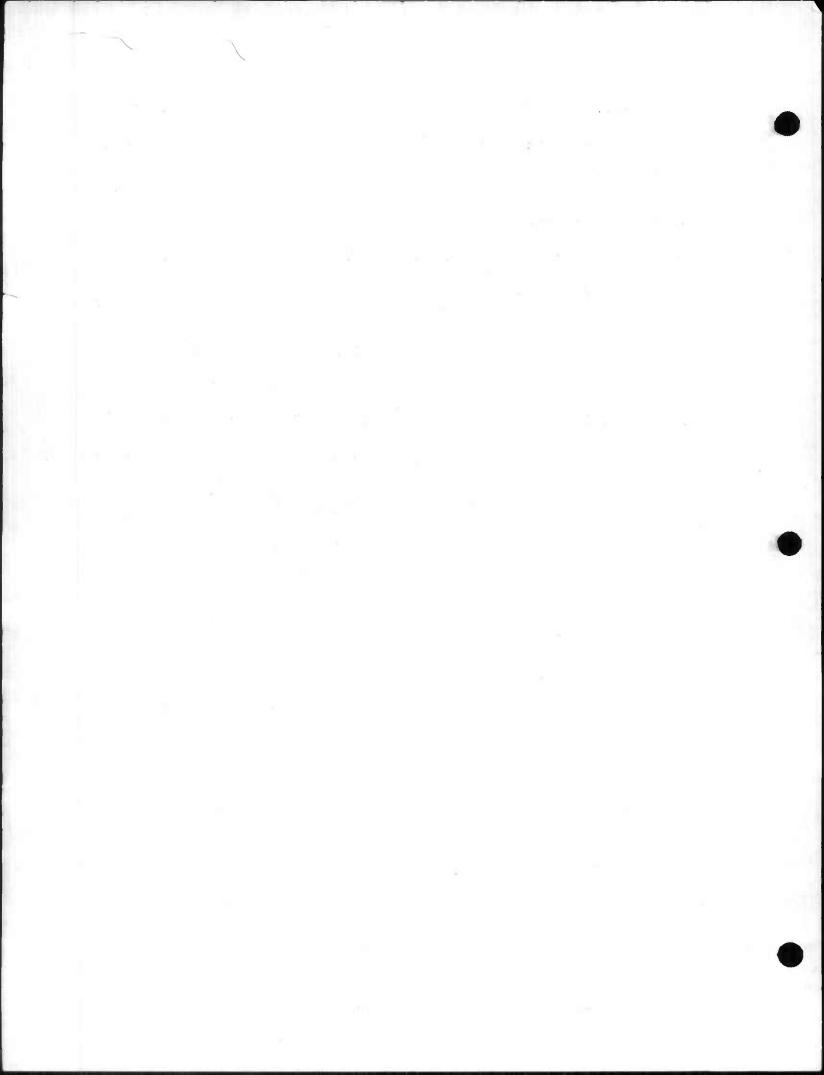
Baltimore, Maryland 21215-0020

with the Maryland

To the Hospital of within 24 hours of To the Funeral D completely filled I

State Registrar 31. Deta filed (Month, Day, Year)

AUG2 8 199



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3 Time of Death AKINS **Physician** Se Almber Z Barbara A 9 00 AM /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Hay and Hedical Baltimore City If Under 1 Year If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funeral** Months Days Min. Hours 10 M 20 F 220-04-7490 27 Yrs Director 08-12-70 Md Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Manyland nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23s or 28s-1 show mix! If item 27 is marked other than "natural", or interest above mix or other traumatic event, in Mendical Experiment man be notified at 10a State 10c. City, Town or Location 10b. County 10d Inside City Limits Md NA Baltimore Director 1⊠Yes 2□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1920 Druid Hill Avenue 21217 USA Funerai 12. Was Decedent Evar In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yas 2 1 No If Yes, Give Year or Detes: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled 12th Grade Unemployed 17. Father's Name (First, Middle, Last) 18. Mother's Nema (First, Middle, Maiden Sumame) Be Akins Richard Mary Alcorn 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 21217 2007 Harlem Avenue Baltimore, Maryland Akins 20b. Placa of Disposition (Nama of cemetery, crematory or other place)
Voshell Mem. Gardens 09-10-97 Dundalk, Md. 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata permit. Pege Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funaral Service Licensae 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only ona cause on each line. Approximata Interval Between Onsat and Death **Physician** /Medical Immediate Ceuse (Final Brain homiation disaasa or condition resulting In daath) Examiner Due to (or as a consequence ot): Zwales Examiner Dain Mass physicien and the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or es a consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequenca of): 90 use Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown 4 Rus pkm Mikelyo Stophass in Records, 2 24b. Were autopsy findings available prior to completion of cause of deeth? page 2 should 24e. Was an autopsy performed? Completed hes 1 Yes 2 No certificate 1 Yes 2 NO Division of Vital Attending Physician: Be 25. Was case referred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred After 1 Natural P Hospital or Attending 24 hours effer death. • Funeral Director: Afr 5 Pending Investigation 1 Yes 2 No 2 Accident 3 Sulcide 6 Could not be 28e. Place of Injury - At home, tarm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) in by 4 Homloide 16 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end menner stated. 29a. Certifier To the Hosp within 24 hos To the Fune completely fi Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) by Sel NO DS007

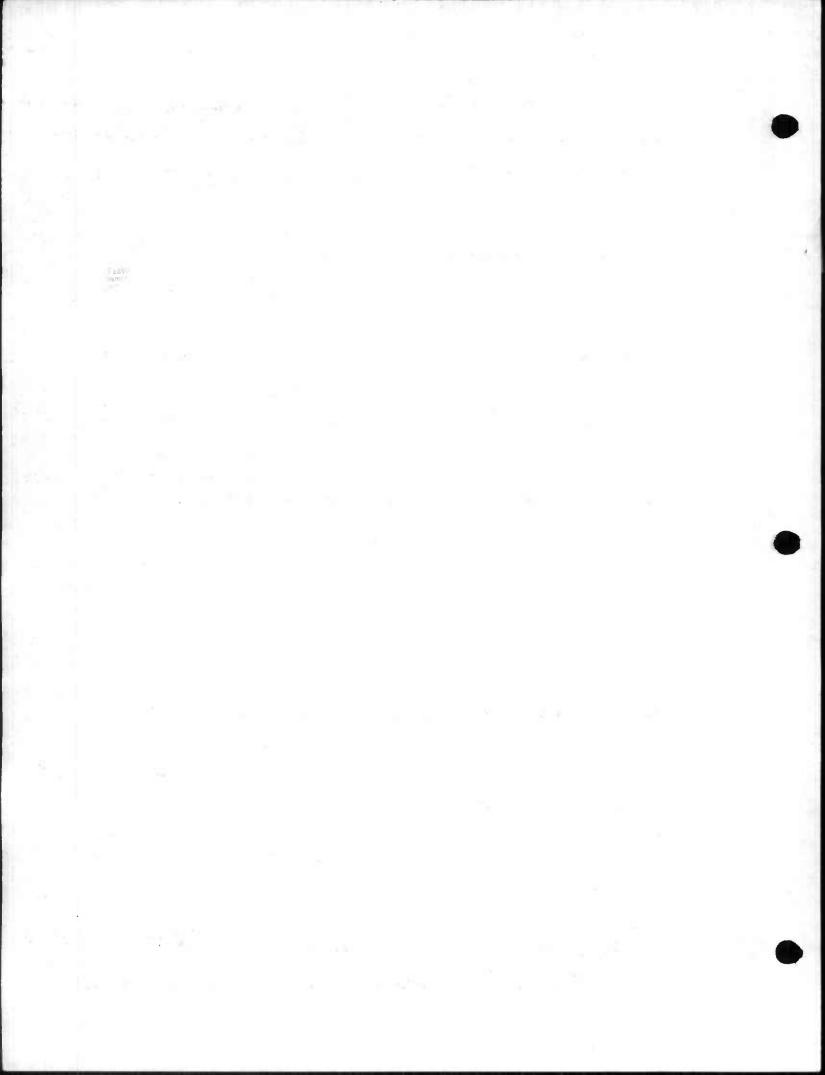
of person who completed cause of death (Item 23e) (Type, Print)

Treffany Uzc Treffany Uzc (ear) 182, Registrar's Signature (ear) 182, Registrar's Signature (ear) 182, Registrar's Signature

22 South Greene Street Baltimore, Md.

State Registrar 30. Neme and and

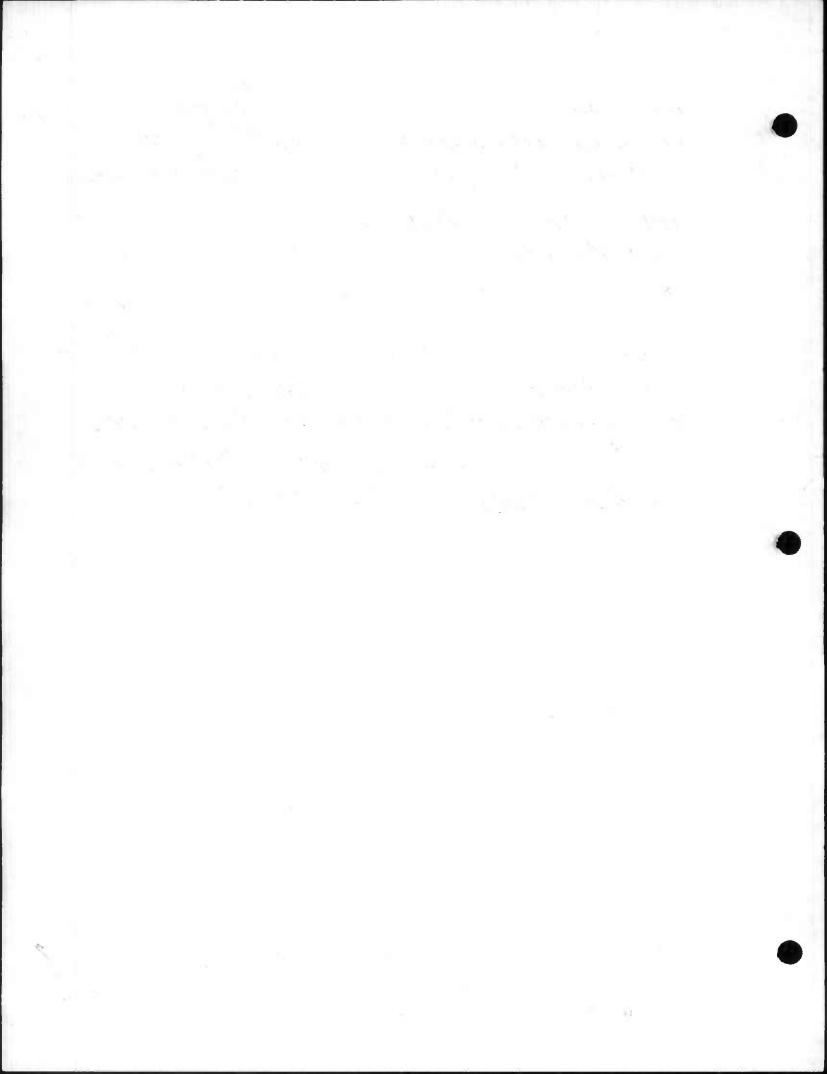
31. Date filed (Month)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 5 Month 5 **Physician** Alesia Alden
4a. Facility Name (If not institution, give street and number) 4c. County of Death /Medical 4b. City, Town, or Location of Deeth **Examiner** Balt.
If Under 24 Hrs. Retirement CTR If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** 1□ M 2 + Months Days Hours 217-14-5401 90 Yrs. Director 06-14-1907 MASKAND Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 Nes 2 No Director md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 101N. Sond 238 4.5.9. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Heme Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours atter Department of Health and Mental Hygiene. International internation of the merked other than "natural; or the any injury or other traumatic event, the Medical Estimina 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1™ Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: WHITE 1 ☐ Yes 2 No Specify: by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DEPARTMENT STORE 12485 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) LOYAL R. ALDER FRANCES GERMANY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) BALTO, M. ZIZ-101 NORTH BOND ST. CROYLE (AGMENTSTRATE) 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility HENRY W. SENKINS & SONS CO. 4905 YOK R. BAZIO, M. 2121 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. **Physician** /Medical tmmediate Cause (Final disease or condition resulting in death) DEMENTIA Examiner Due to (or as a consequence of) Physician/Medical Examiner physicien and the burlef-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ATHRNOSCLE ROSIS Division of Vital Records, ò 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hoapital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was cese referred to medicel examiner? Be 26. Piace of Death (Check only one) Hospitai: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of Injury 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 8 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number ted cause of death (Item 23a) (Type, Print) 0



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month WALTER L. ABELL Sept. 1997 8:45 a.m. 4a. Facility Nama (if not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Fort Howard

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day, Year May 29, 1929 VA MHCS Fort Howard Division Baltimore 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) Birthpiaca (Stata or Foraign Country) 1₩ M 2□ F 68 217-24-097 Yrs. Maryland Usuai Rastdence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Baltimore Maryland Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 21227 United States 5516 Selma Avenue 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, apecify Cuban, Maxican, Puarto Rican, atc.) Raca - Amarican Indian, Black, Whita, atc. 1 ∑Yas 2 ☐ No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Marriad 1 ☐ Yas 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White 18a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Eiamantary/Secondary (0-12) College (1-4or 5+) Paper Company Security Guard 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumema) Marguerite Stein Frank O. Abell 19e. Informant's Name/Reletionship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) Frank E. Abell Brother 209 S. Calhoun Street Baltimore, Md. 21223 20b. Placa of Disposition (Nama of cematary, cramatory or other place)
Maryland Veterans 20a. Mathod of Disposition 20c. Location - City or Town, Stata 15 Burial 2 Cramation 3 Ramoval from Stata 4 Donatton 5 Other (Specify) 9-10 Cemetery-Crownsville 1997 Crownsville, MD 22. Nama and Addrass of Facility Ambrose Funeral Home, Inc. 21. Signature of Faneral Sarvice Licensee 23e. Part 1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Death Immediata Causa (Final disaasa or conditior rasulting in daath) Cancer of Esophagus with liver and bone mets Due to (or as a consequence of): Sequantially list conditions, if any, taading to immadiata cause. Entar Undarlying Cause (Disease or Injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of): Dua to (or as a consequanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of death? 1 Yas 2 No 1 ☐ Yas 2 No 25. Was case rafarred to medical 26. Placa of Death (Check only one) axaminar? Hospitat: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yas 2 No 27. Mennar of Death 28a. Deta of Injury (Month, Dey Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how tnjury occurred 1 Natural 5 Pending Invastigation 1 ☐ Yes 2 ☐ No 2 Accident

Physician /Medicai Examiner

Physician

/Medical

Examiner

Funeral

Director

r 28a-f s

traumatic event, the Medical Examiner must be

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Вета 23а

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Pages 1 and 2 should be nent of Health and Mental

Department of Health an important: If them 27 is

Director

Funeral

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Completed

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filed within 72 hours after

WALTER L. ABELL altimore, Maryland 21215-0020

P.O. Box 68760,

Records,

Division of Vital

the buriel-transit physician Physician/Medical ettending I by Completed page 2 Be 2 funeral Medical Certification:

requires that the deeth certificate be axecuted à signed b peed certificate or Attending Physician: After death. Director: after To the Hospital o within 24 hours aff To the Funeral Di completely filled in

12

29b. Stgnatura and titia of certifier

3 ☐ Suicide

29a. Certifian (Check only

4 Homtcide

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licensa number 30528 29d. Data signed (Month, Day, Year)

28f. Location (Street and Number or Rural Routa Number, City or Town, Steta)

30. Nama and addrass of person who complated causa of death (tam 23a) (Type, Print)

DUGGIRALA, BALA M.D. 9600 NORTH POINT ROAD, FORT HOWARD, 21052 31. Data filed (Month, Day, Yaer)

State Registrar

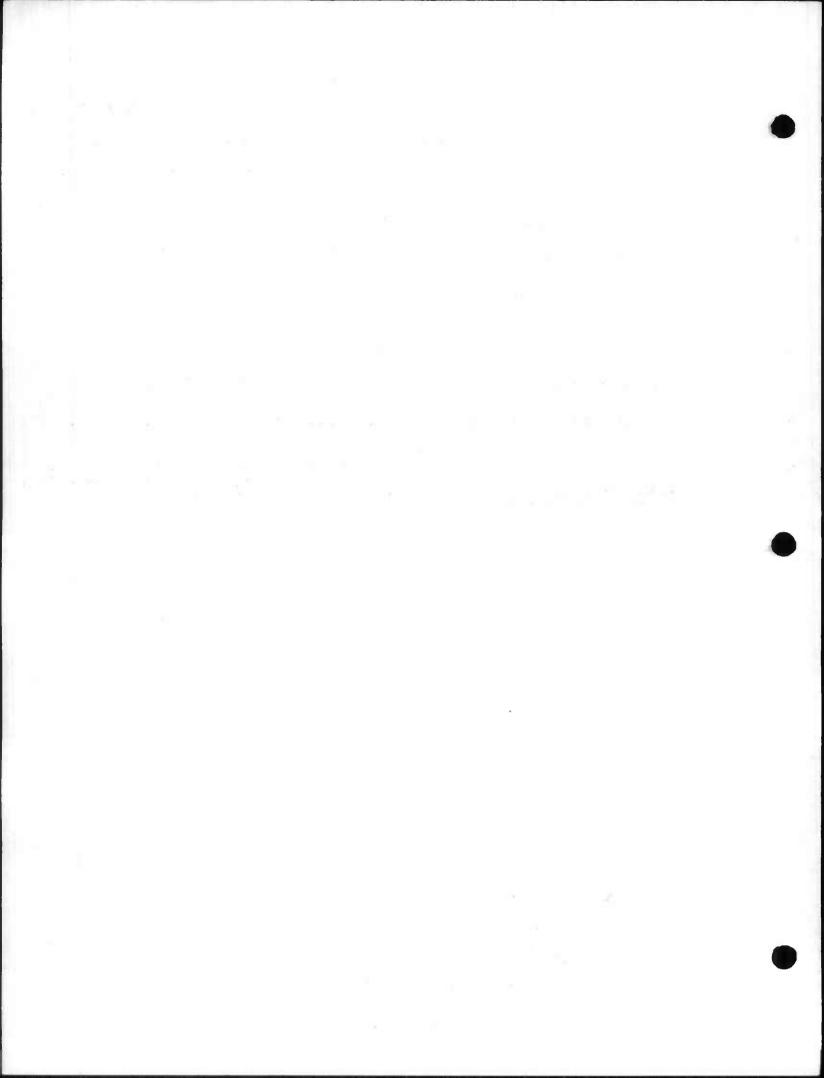
SEP 0 9 1997

6 Could not be

32. Registrar's Signatura whia Davidson-Randon

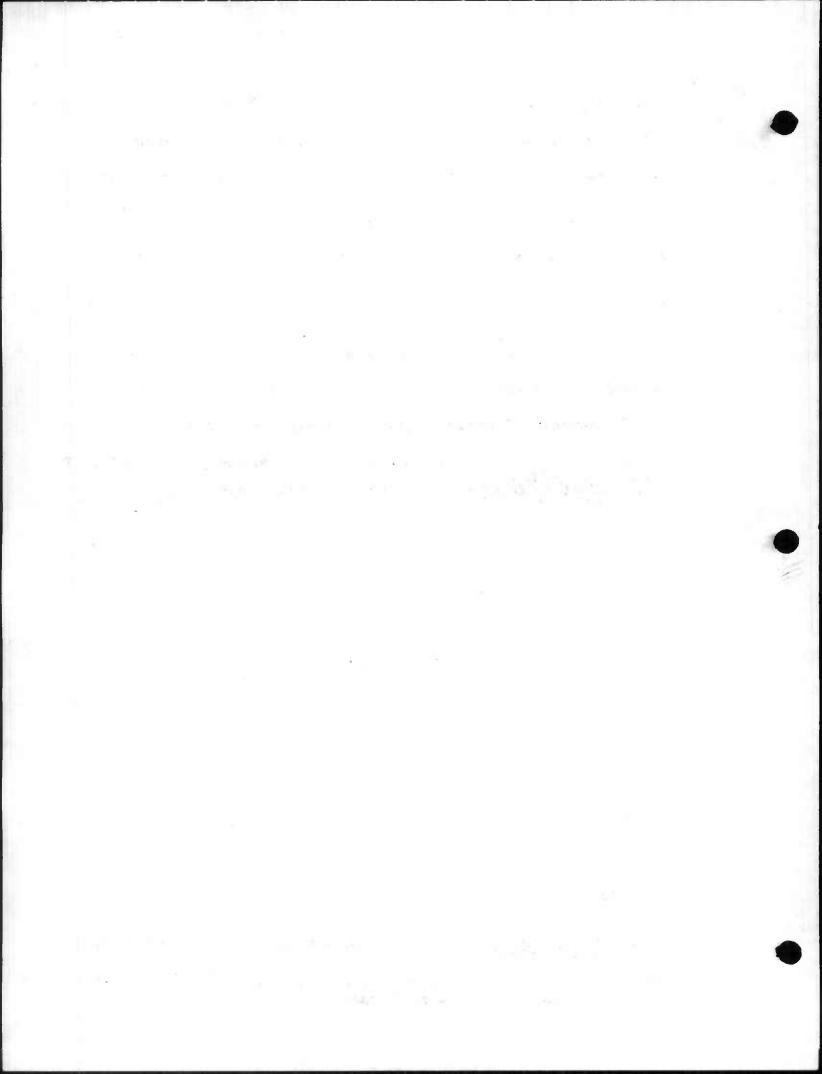
28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify)

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene 07 2771

| | | | | | | Certific | ate of | | | Reg. No. | 1 2 | 1211 | | | | |
|--|---|--------------|---|--|----------------------------------|---|-------------------------------|--|--|--------------------------------------|---------------------------------------|---|--|--|---|--|
| | ysici: Medic | _ | 1. Decedant's Nama (First, Middla, Las | 44 | | | 34 | RGES | 2. Data of De Month Hug | Day 30 | Yaar 1997 | Tima of Death 8 50/AM | | | | |
| Ex | amin | er | 4a. Facility Nama (If not institution, give | | | | | 4b. City, Town, or | | 4c. County | of Death | | | | | |
| | | | 7001 N. Charles 5. Social Sacurity Number 6. Se | | . On the last | A Land of Hills | ndar 1 Yaar | Towso | | | imore | | | | | |
| _c Fund Direct | | | | M 2131€ | 76 | Yrs. If Ur Mont | | Hours Min | . (Month, Da | th y, Year) 4, 1920 | 9. Birthplaca Country) Maryl | (State or Foreign | | | | |
| ryland | H | | 10a. Stata 10b. County | | 10c. City, | Town or Location | | | | | 10d. li | nsida City Limits | | | | |
| Be-fs | office | Director | Maryland Baltimo | re | | Towson |) | | | | 1 | I□Yas 2X No | | | | |
| with th | 8 | 튭 | 10e. Street and Number | | | 10f. | Zip Coda | | | 10g. Citizan of \ | What Country? | | | | | |
| eath | Tage 1 | eral | 7001 N. Charles | Street 12. Was Decedant | Ever le II C | 12 Wee De | 2120 | | Consider Manager Man | | SA | adla a | | | | |
| 020 ours after d | Examiner | by Funeral | 1 □ Navar Marriad 2 □ Marriad 3 ☼Widowed 4 □ Divorced | Armed Forcas? 1 Yas 2 1 If Yas, Give Yaar or Datas: | | | | dispante Ortgin? (S an, Maxican, Puar Specify: | to Ricen, atc.) | Specify | e - Amarican Inck, Whita, atc. White | | | | | |
| d 21215-0020 filled within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23s or 28s-1 show | ne Medical | Completed | 15. Decedent's Edi (Specify only highest grad Elementery/Secondery (0-12) | da complatad) College (1-4or t | 5+) | lifa. DO NO | work dona Tusa ratire | during most of wo d) | orking | | usinass/Industr | у | | | | |
| d 212 filed with Hygiene. wither than | 5 | | 12 17. Fathar's Nama (First, Middla, Last) | 3 | | Registe | erea i | | ma (First, Middla, | Nurs Maidan Sumen | - | | | | | |
| | | To Be | Rowland | Wallis | | | | Esthe | | | /le | | | | | |
| faryla 2 should I end Men Is marke | traumatic | | 19a. Informant's Name/Ralationship (T | | | 19b. Mailing Addr | ass (Street | | | | | (a) | | | | |
| | ther | | Mary C. Cornwe | | 20b. Pla | 1910 F | Rustic | View D | r., Fink | sburg, | MD 2 City or Town, \$ | 1048 Steta | | | | |
| Pages nent of nnt: If it | Juy or | | 1 N Burial 2 ☐ Cramation 3 ☐ I 4 ☐ Donetion 5 ☐ Othar (Specify, | | | . Zion C | | | /2/1997 | Churc | hville | MD | | | | |
| Baltimore, Permit. Pages 1 ar Department of Heal | any injury 900a. | | 21. Signature d'Eunarai Sarvice Lican | lary | _ | 22. Name | and Addra | Funeral | Home | | | | | | | |
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| o death the ettern the ettern had for a | of be | Physician/ | Part II. Other significant conditions con | ntributing to death be | it not result | ing in tha undarlyin | g ceusa gh | ran in Part I. | art I. 23b. Did tobacco use contribute to the cause of | | | | | | | |
| es that the igned by the | 9 | by Phy | | | | | | | 10' | Yes 2□ No | 3 Probably | Unknown | | | | |
| aw requires to be seen s | S should | Completed | | | | | | | 24a. Wes perfo | an autopsy med? | available | utopsy findings la prior to tion of ceusa n? | | | | |
| The date h | page | 000 | | | | | | | 101 | as No | 1 □ Yas | 8 2□ No | | | | |
| Of VITAL I | octor | n n | 25. Was cesa rafarred to medical axaminar? | 1 2 | | | | | ath (Check only o | na) | | | | | | |
| Physic this control | ai ' | <u> </u> | T Tas AND INO | lospitai: 1 ☐ Inpatia | | R/Outpatient 3 | DUA | | loma 5 Rasio | | | | | | | |
| i or Attending F after death. Director: After | ne runer | Cermication: | 27. Mannar of Daath Natural 5 Panding invastigation | 28a. Date of Injur (Month, Day | Year) 2 | 8b. Tima of Injury M | 28c. Injur Wor | yat k? Yes 2 □ No | 28d. Dascribe how injury occurred | | | | | | | |
| Hospital or Attend 24 hours after deat Funeral Director: | kg ui bei | Certific | 3 ☐ Suicida 8 ☐ Could not be datarmined | 28a. Place of Injubuliding, atd | iry - At hom . (Specify) | ia, farm, straat, fac | tory, office | | 28f. Location (S City or Tox | Straat and Numb m, Stata) | er or Rural Rou | ita Number, | | | | |
| To the Hospital or Attending I to the Funeral Director: After Compilers of the funeral Director: After Compiled in by the fine for the funeral Director: After Compilers of the funeral Director in th | preseny rii | edical | 29a. Certifiar (Check only one) Certifying Physical Examination (Check only one) | alclan: To the best of ner: On the besis of and mannar sta | axaminetio | edge, daath occurr n end/or investigat | ed et tha tir ion, in my o | na, data and piace pinion, deeth occu | e, end dua to tha dirred at the time, | causa(s) and ma dete end piaca, e | nnar as stated. and due to the o | cause(s) | | | | |
| To the To the | E CO | | 29b. Signature and title of cartifier 29c, License number 29d, Date signed (Month, Day, Year) | | | | | | | | | Year) | | | | |
| | 30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print) AH-GHILADI, MR. 7600 OSLER Dr. Towson | | | | | | | 8-30 | 0-9 | 7 | | | | | | |
| | | | 30. Nama and address of person who co | omplated cause of de | | (Type, Print) | 54 | = N D | c. Thu | SSON. | MN | 21204 | | | | |
| 111 | Stat | 9 | 31. Data filad (Morg.P.P. 10arg 19 | 97 32. Registry | Mas Day | islson-Randa | se. | | , 00 | 0,-, | 101 | / | | | | |



State of Maryland / Department of Health and Mental Hygiene Items10D.14 9-9-97 FilmG751 W.H.Per F/H Certificate of Death 1. Decedent's Nama (First, Middla, Last) 3 Time of Death 2. Data of Death Month **Physician** 4c. County of Death 0635 Am REDA 4b. City, Town, or Location of Death 4c. /Medical 4a. Facility Nama (If not institution, giva street and number) **Examiner** BALTIMORE GILCHRIST CTR. HOSPICE OF TOWSON BALTIMORE if Under 24 Hrs. 8. Data of Birth (Month, Day Year) MARCH 15, 5. Social Sacurity Number 7. Aga (In yrs. last birthday) If Undar 1 Yaar Birthpiaca (Stata or Foraign Country)
 CANADA **Funeral** 1 M 2 F Months 71 Yrs. 1926 218-30-6286 Director Usual Rasidance of Dacedani 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 10 Yas 2 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 13 POMONA SOUTH 21208 #11 U.S.A. Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. White 1 ☐ Navar Marriad 2 ☐ Married 21215-0020 1 ☐ Yas 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITEWHITE Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education 16b. Kind of Business/Industry filed within 72 (Specify only highast grada complated) Etamantary/Secondary (0-12) Collaga (1-4or 5+) 12 MANAGER ASSOC. JEWISH CHARITIES ould be fit.
T is ment Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be Pages 1 and 2 should FLUXGOLD HARRY TILLIE SHERMAN 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) of Health a ARNOLD BETTER / HUSBAND 13 POMONA SOUTH #11 BALTIMORE, MD 21208 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramovai from Stata 4 ☐ Donation 5 ☐ Other (Specify) = b BETH EL MEMORIAL PARK 9/7/97 RANDALLSTOWN, MD 21. Signatura of Funaral Sarvica Licensee 22. Nama and Addrass of Facility Sol Levinson & Bros., Inc. ayi 8900 Reisterstown Road Pikesville, MD 21208 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intervat Batween Onsat and Death **Physician** /Medicai Immediata Causa (Final Breast Concer 6 menths disaasa or condition rasulting in daath) **Examiner** The law requires that the death certificate be executed Sequantially list conditions, if any, laading to Immadiata ceusa. Entar Undarlying Causa (Disaasa or Injury that initiated evants rasulting In daath) Last Dua to (or as a consequence of): Box 68760 Physician/Medical Dua to (or as a consequance of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part 1. P.O. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 22No 3 Probably 4 Unknown Records, by 24b. Wara autopsy findings availabla prior to complation of ceusa of daath? 24a. Was an autopsy performed? Completed 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate of Vital offer death.

Director: After this certifica Be 25. Was casa rafarred to medical 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Nother (Specify) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yas 2 No 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Tima of 28d. Dascribe how Injury occurred 5 Panding invastigation 1 Natural None 2 Accidant 3 Suicida 6 Could not be datarmined 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) filled in by 4 Homicida Hospital
 24 hours e
 Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29a. Certifian To the Hosp within 24 ho To the Fune completely fi 29b. Signatura and titla of certifian 29c. Licansa number 29d. Data signed (Month, Day, Yaar) wo

(Herp 23a) (Type, Print)

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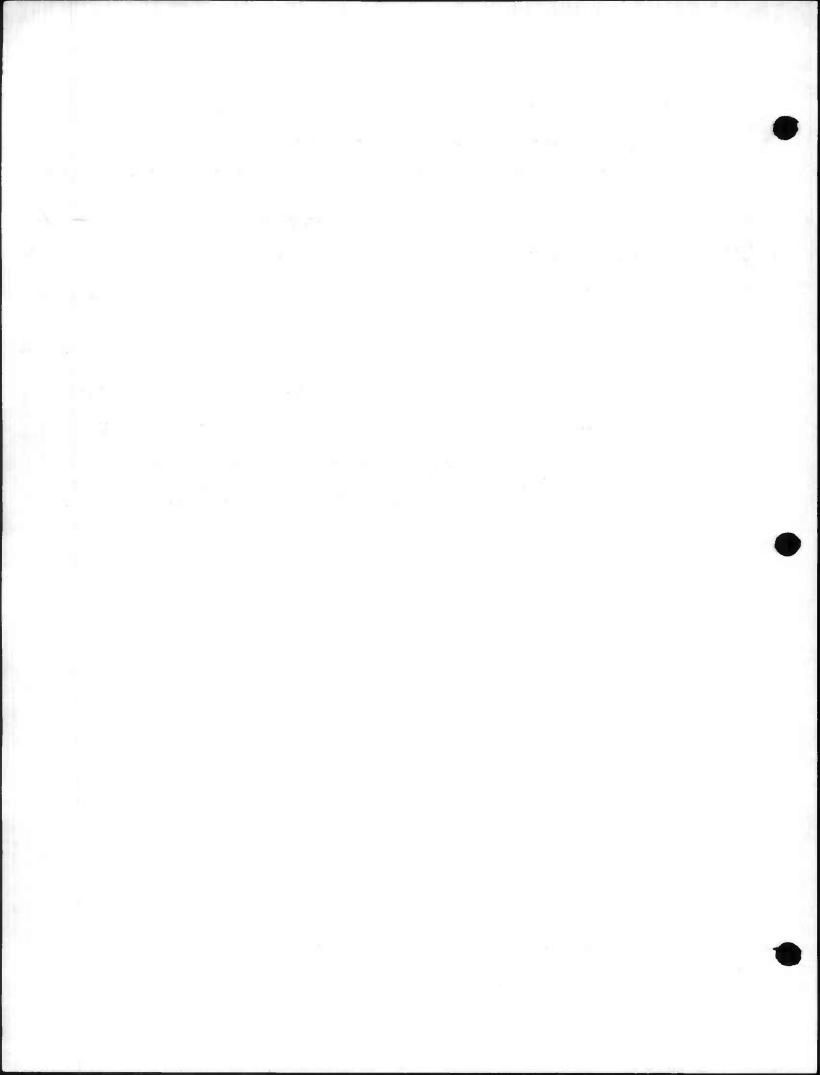
62/Ragintaris Signature Daydon-Randelle

N. Charles St. Balto, nd. 21204

Registrar

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State



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | 1. Decedent's Neme (First, Middle, Last) Certificate of Death 2. Detect of Deeth | | | | | | | | | 3. Term of Death |
|--|---|---|--|--|---|--|--|---|--|--|
| sician | | | imilian | RT | EDERMANN | | Month | nber 3, | Year | 9:29 A |
| dicai | | e. Fecility Neme (If not Institution, give | | ות | EDERHANN | 4b. City, Town, or Lo | • | | | 9.49 8 |
| miner | 1 | | Control of the Control | 0 | | | | 100000000000000000000000000000000000000 | | |
| rai | 5. | Franklin Square Social Security Number 6. Sec | | (In yrs. last birt | | Rosedale | | | timor | |
| al of | | | D | | Yrs. Months Deys | Hours Min. | 8. Dete of Bir (Month, Da May 17 | , 1912 | Mai | ece (Stete or Forei ry) cyland |
| tor | 10 | Oa. State 10b. County 10b Baltimo: | | 10c. City, Town | | timore Cou | unty | | 10 | id. Inside City Limit |
| Funeral Director | 9 | 0e. Street and Number 512 Belair Rd. | | | 10f. Zip Code | 1236 | | 10g. Citizen of V USA | Vhet Count | ry? |
| by | | 1. Marital Stetus | 12. Was Decedent E Armed Forces? 1 Yes 2 No if Yes, Give Year or Dates: | | 13. Wes Decedent of If Yes, specify Cub | | ecify Yes or No Rican, etc.) | | a - America ok, White, e | itc. |
| Сощріете | | 15. Decedent's Edu (Specify only highest grad | le completed) | | Decedent's Usuel Occu (Give kind of work done life. DO NOT use retire | pation during most of work d) | ing | 16b. Kind of Bu | usiness/Ind | ustry |
| E | | Elementary/Secondery (0-12) | College (1-4or 5+ |) | | Compiler | | CSX | | |
| O | 17 | 7. Fether's Neme (First, Middle, Last) | N/A | | dilli | 18. Mother's Nem | e (First, Middle, | | ne) | |
| To Be | | Gustav M. Biederma | ann | | | | W. Buel | | 1 | |
| F | | 9a. Informent's Name/Relationship (Ty | rpe, Print) | 19h | Malling Address (Stree | | | | State. 7in | Code) |
| | | Charles C. Reiche | | | 9516 Belair | | | | | 2300) |
| | 1 | Oe. Method of Disposition | 1.0 | | Disposition (Name of y, cremetory or other ple | | Dete Dete | 20c. Location - | | vn. Steta |
| * | " | XXBurial 2 Cremetion 3 DR | | | | | | | | |
| | - | 4 □ Donetion 5 □ Other (Specify) | | St. M | ichaels Lut | | | | more | , Ma. |
| DUCE | 2 | 1. Signature of Fuheral Service License | n Shin | alin | ²² E ^{Name and} Addr 11750 B | ssann Fund elair Rd. | | | i. 210 | 087 |
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| ie i | CEC | dequentially list conditions, eny, leeding to immediate ause. Enter Underlying ause (Disease or injury net initiated events | S | | he Colon | | | | | |
| Physician/Medical | re | esuiting in deeth) Last | d | ue to (or as a c | onsequence of): | | | | | |
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| 28 | Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Per Liver Failure | | | | | | 23b. Did tobacco use contribute to the ca 1 ☐ Yes 2 ☒ No 3 ☐ Probably | | | ably 4 Unknow |
| y Ph | • | | | | | | | an autonsy | 24b. We | re eutopsy finding |
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32. Registrer's Signeture
Julia Davidson-Randall

State

Registrar

SEP 0 9 1997

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Dete of Deeth Brown Month September City, Town, or Location of Deeth 6 4e. Fecility Neme (If not institution, give street end number) of Maryland Medical System K 6. Sex 7. Age (In vrs. lest birthdey) It Under 1 Year Baltimore university if Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yea 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) 1□M 2□F X Months Deys 86 216-18-6823 AUG. 22, 1911 VIRGINIA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yes 2 No MARYLAND N/A BALTIMORE CITY 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 505 N. STREEPER STREET 21205 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, Whita, atc. 1 Never Married 2 Married 1□Yes 2□No Specify: 3X Widowed 4 ☐ Divorcad **NEGRO** Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementary/Secondery (0-12) Coilega (1-4or 5+) HOUSEKEEPER BANK Unknown 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) UNKNOWN LUCINDA 19a. informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Coda) BARBARA HARRIS - DAUGHTER IN LAW 505 N. STREEPER ST. BALTO, MD. 21205 20b. Plece of Disposition (Name of cametery, crametory or other place) 20e. Method of Disposition 20c. Location - City or Town, Steta Buriel 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) ZION CEMETERY SEPT. 11, 1997 BALTO, MD. re of Funeral Service Liceos 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. 23a. Part1. Enter the disease, or complications that a set the leath. Do not enter the mode of dying, such as cardiac or raspiretory errest, shock, or heart feilure. List only one cause on each line. PRESTON ST. BALTO, MD. Approximeta interval Bety immediate Cause (Final disease or condition resulting in death) reumonic Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieled events resulting in daeth) Lest Due to (or es e consaquenca of) Due to (or es e consequenca of) Pert ii. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Mellitis Diabetes 24e. Wes en eutopsy performed? 24b. Ware autopsy findings evailable prior to Dementia completion of cause of deeth? 1 🗆 Yas 2 No 1 ☐ Yes 2 ☐ No

Physician /Medicai Examiner

Physician

Examiner

Funeral

Director

28a-f show

al Hygiene. other than

on and Mental F

Department of Health, Important: If Item 27 is any injury or other tra

Pages 1 and 2 should

21215-

Baltimore, Maryland

Box 68760,

Division of Vital Records, P.O.

Director

Completed by

Be

21. Sign

/Medical

10e. Stete

ettending physician for use as the buria ed by the a certificate this After t

Completed by Physician/Medical

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The law requires that the death certificate be executed or Attanding Physician: Certification: s after death.

I Director: A
od in by the fo death.

To the Hospital of within 24 hours at To the Funeral D completely filled I 1

25. Wes case referred to medical exeminer? 1 Yes 2 No 27. Manner of Deeth 1 Naturel 5 Pending Investigation 2 Accidant 3 Suicide

29e. Certifiar

(Check only

29b. Signature and title of offit

4 Homicide

6 Could not be determined

28e. Deta of injury (Month, Dey Year)

1 inpatient

28e. Place of injury - At home, ferm, straet, factory, office building, etc. (Spacify)

28b. Time of

2 ER/Outpetient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work?

1 ☐ Yas 2 ☐ No

26. Placa of Deeth (Check only one)

Location (Street end Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29c. Licensa number

1 Certifying Physician: To the bast of my knowledge, deeth occurred et the time, data and piece, end due to the ceusa(s) and menner es stated.
2 Medicat Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, data and piece, and due to the ceusa(s) end menner stated.

29d. Date signed (Month, Day, Year)

30. Neme and eddress of person who complated cause of death (item 23e) (Type, Print)

Hospital:

Greene Street Baltimore, Haryland 21201 MD

31. Dete filed (Month, Day, Yeer) SEP 0 9 1997

Registrar

and the state of I Series a research a finite

State of Maryland / Department of Health and Mental Hygiene

ASP

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Day Ernest Blunt /Medicai 4b. City, Town, or Location of Deeth 22 1997 4c. County of Death 2330 P 4a. Fecility Nama (If not institution, giva street and number) Examiner Baltimore City MARYLAND SHOCK TRAUMA BALTIMORE If Undar 1 Yaar If Under 24 Hrs.

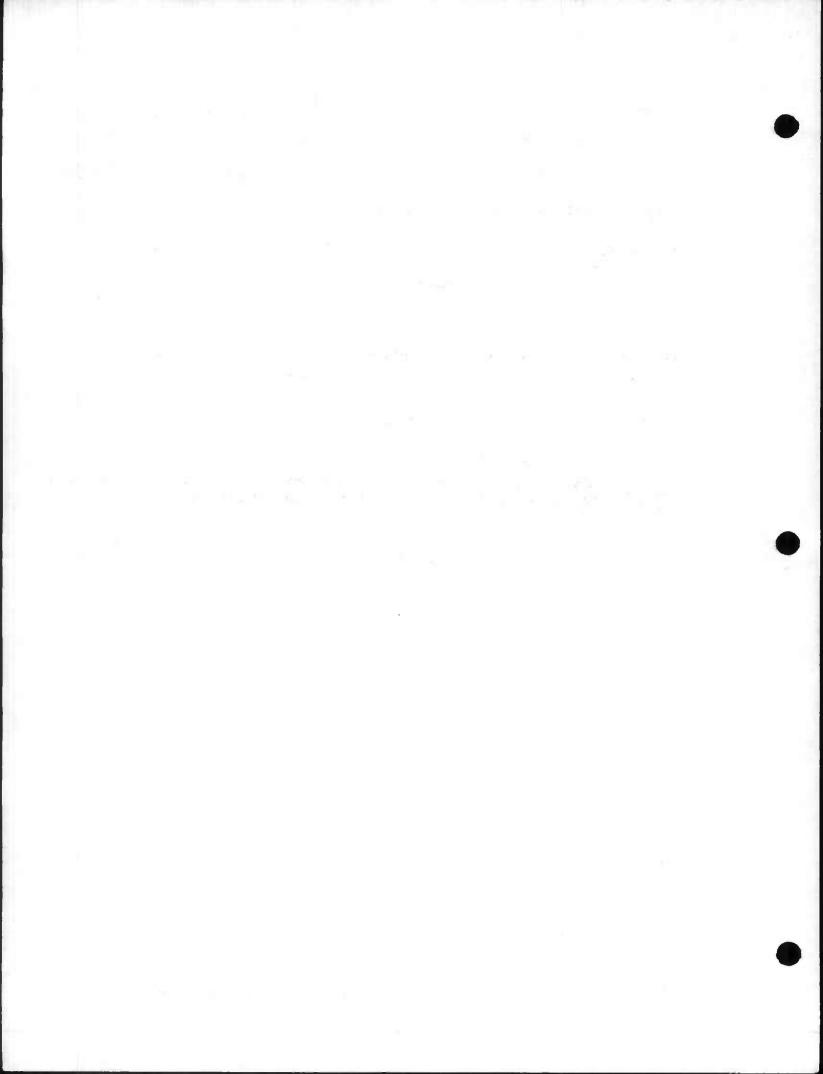
Months Deys Hours Min. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplece (Stata or Foraign Country) **Funerai** Deys Months 1₩ M 2□ F unknown Yrs. unknown Director unknown Usual Rasidance of Dacedant 10b. County 10c. City, Town or Location or 28a-f ahow 10d. Inside City Limits the Medical Examiner must be notified at Baltimore Baltimore City Maryland 1 Yas 2 No Director 10e. Street and Number 10f. Zin Code 10g. Citizan of What Country? 21217 U.S.A. 1520 W. North Avenue 23a Funeral 11. Maritai Status unknown Herne: 12. Wes Decedant Evar in U.S. Armed Forcas? Was Decedanf of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Rece - Amarican Indian pemit. Pages 1 and 2 should be filed within 72 hours after I Depertment of Heelth and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or iter eny injury or other traumatic event, the Medical Examinat 1 Yas 2 Nunkrown 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specity: Black þ 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Eiamenfary/Secondary (0-12) Collega (1-4or 5+) unknown unknown unknown unknown 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) Be unknown unknown 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straet and Number or Rural Routa Number, City or Town, Stata, Zip Coda) unknown 20b. Place of Disposition (Nama of cematary, cramatory or othar place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Crametion 3 ☐ Ramoval from Stata 4 □ Donation 5 □ Othar (Specify) in state Ronald S. Wade 22 State Anatomy Board, 655 W. Baltimore Street Director Baltimore, Maryland 21201 Fart . Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, thock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** Headinjuries Immediata Causa (Final diseasa or condition rasulting in daath) /Medicai Examiner Dua to (or as a consequence of): Physician/Medical Examiner ician and buriel-transit Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disease or Injury that initiated avants resulting in death) Last Dua to (or as a consaquanca of) physician s the buriel Box 68760. The law requires that the death certificate be Dua to (or as a consequence of) for use as 950 P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deefh? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24a. Was an autopsy performed? 24b. Wara autopsy findings should Completed available prior to complation of cause of death? page 2 certificate has 1 Nas 2 No 1 M Yas 2 No or Attending Physician: 25. Was casa rafarred to madical examinar? Be 26. Placa of Daath (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient > DOA Othar: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) Yas 2□ No Certification: To After this funeral 28a. Data of Injury (Month, Dey Year) 27. Mannar of Death 28d. Dascribe how injury occurred Sulfict jumped out 28b. Tima of Injury 28c. Injury at Work? 5 Panding investigation 1 Natural death. 1 Yas 2 No 2 Accident 8-22-97 2213 the 24 hours after deati Funeral Director: 6 Could not be datarmined 3 Suicide 28a. Place of Injury - At homa, farm, streef, factory, office building, afc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, State) 1520 W. North Auc filled in by 4 Homicida Home Baltimore city 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

Applicate Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Cartifian (Check only one) within 2 29b. Signatura and titla of certifiar

Donald & Wing MMD 29c. Licansa numbar 29d. Defe signed (Month, Dev. Year) AUGUST 23, 1997 O.C.M.E 30. Nama and addrass of parson who complated causa of death (Itam 23a) (Type, Print)

Julie Device Palle Penn Street, Baltimore, Maryland 21201

State Registrar DONALD G. WRIGHT



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To The Manager

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| Baltimore, Maryland 21201 E3a. Fart. Shier the disease, or combiditions that caused the deam. Do not enter the mode of dying, such as cardiac or respiratory errest. Immediate Gauss (Phasi disease or pondition) Due to (or se a consequence of): Bequentially first conditions. If any, leading to immediate gauss, graph (indepting) Cause (Disease or index) Due to (or se a consequence of): Due to (or se a consequence of): C. Due to (or se a consequence of): Due to (or se a consequence of): C. Due to (or se a consequence of): Due to (or se a consequence of): 23b. Did tebacog use contribute to the celle- | 1 Burisi 2 Cremetion 4 Denetion 5 Dother (8 | Specify) in st | | on of Diago melety, crem | narroy of o | ne oi Iner els | 06) | | Dele | 20s. Location | - City or Tu | ma, Siele |
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| Part II. Other significant conditions contributing to death but not resulting in the unidaritying cause given in Part I. 23b. Did tebacco use contribute to the cause. 1 1 Yes 21 No. 8 Probably 4 (| resulting in deeth) | B | | | vence of): | | | | | | | |
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| of deptity. | | | | | | | | _ | 84e. Wne perfo | en autopay med? | \$4p. Wa | Ne autor by fire Nebia prog to apistion of caus |

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25, Was some referred to medical emminer?

NO Year 2 No 27. Menner of Desin

Heapitet: 1 inpatient E ER/Outpatient 380 DOA 28e, Date of Injuly (Month, Day Year)

2213 28e. Piace of Injury - Al home, farm, eveet, factory, office building, etc. (Specify)

Home

260 Injury at 1 Yes 2 No

Others 4 Nursing Home 6 Residence 8 Dolher (Specify) Buffee gumped out winder

26. Place of Death (Chack prily one)

291, Location (Street and Number of Aural Routh Number City of Tomm, State) 1820 W. North A

20a. Contiller (Check only sno) 200. Signature and the of centiler & wing wmD

2 Acoldent
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4 Homioide

1 Contring Physician: To me best of my knowledge, death secured at the time, dete and place, and due to the squeets) and manner as stead.

20 Medical Examiner: On the best of examination end/or investigation, in my opinion, death accurred at the time, date and place, and due to the cauta(a) end manner stated. 29c. License number O.C.M.E

29d. Date signed (Month, Day, Year) AUGUST 23, 1997

30. Name and address of person with completed cause of death (Nam 23s) (Type, Print)

DOMALD G. LL 31. Date find (MOST) 1997 WRIGHT

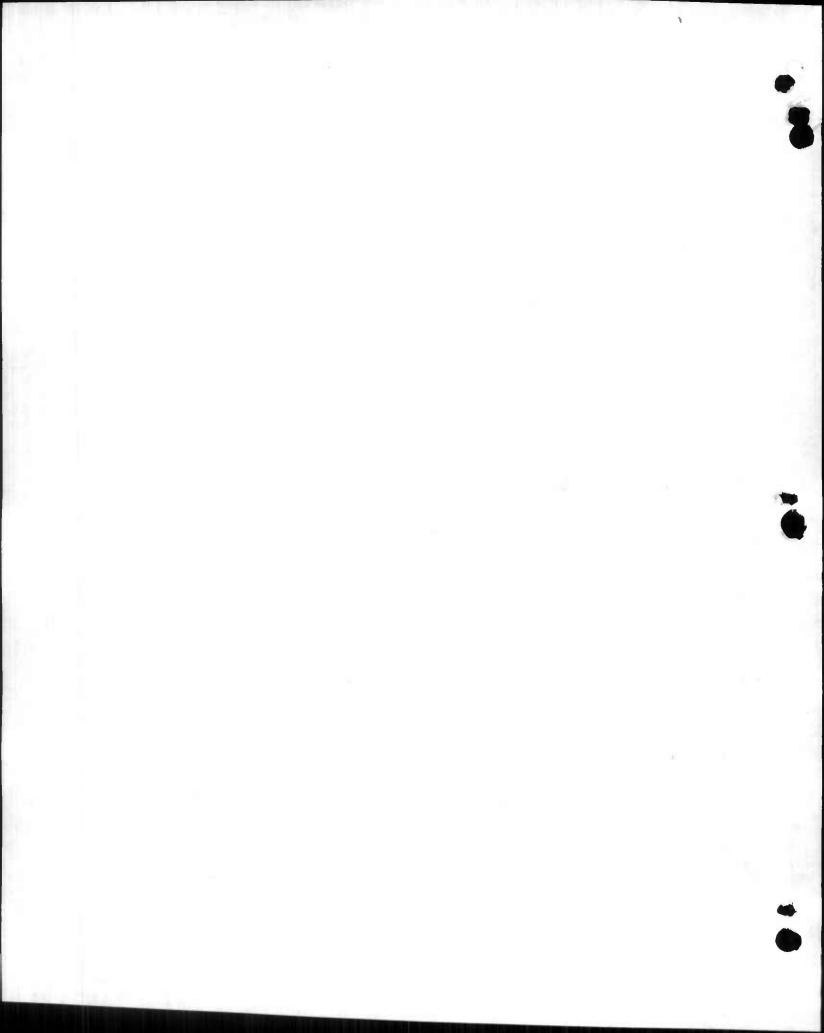
5 Pending investigation

Deniminal

Maryland 21201

Stage Hegistrar

Wedter Certification: To



Please Type or Print in Black indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7 Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Data of Death 3. Tima of Deeth Month Yaar Matilda S, Bishop August 26 1997 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Fairhaven Nursing Home Sykesville Carroll If Under 1 Yaar Months Days If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthpiece (Stata or Foraign Country) Months 1□M 2₩F Yrs. 212-01-1818 89 Jan. 26, 1908 Pennsylvania Usuel Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Carroll Sykesville 1 ☐ Yes 🏖 No 10e. Street and Number 10f. Zip Code 10g. Cifizen of What Country? 7200 3rd Avenue U.S.A. 21784 12. Wes Dacedant Evar in U,S. Armed Forces? 14. Rece - Amarican Indian, Black, White, etc. Wes Decedent of Hispenic Origin? (Specify Yas or No-it Yas, specify Cuban, Maxican, Puarto Rican, etc.) 11. Meritei Stetus 1 ☐ Yes 2 ☑ No If Yas, Give Year or Detes: 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Medical Secretary 17. Fathar's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumama) Alexander Hamilton Bishop Sarah Shreve Wallace 19e. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 739 E. Lake Avenue, Baltimore, Maryland 21212 Alexander Hamilton Bishop III 20b. Pieca of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Crametion 3 ☐ Removel from State 4 Donetion 5 ☐ Other (Specify) 21. Signeture of Fineral Service Licensee Ronal d Director State Anatomy Board, 655 W. Baltimore Street Wade Baltimore, Maryland 21201 23a. Fart1. Enter the disease, of compilections the caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart teilure. List only one cause on each line. Approximeta Interval Between Onset and Death Immediate Cause (Finel disaasa or condition rasulting in deeth) 37 years pertension Due to (or as a consequence of): Due to (or es e consequança ol): 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24e. Was en autopsy performed? 20 No 1 ☐ Yes 2 No

Physician /Medical **Examiner**

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physician

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After

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funeral director,

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Certification:

Medical

29a. Certifier

that the death certificete be executed

Physician

/Medical

Examiner

10a. Stata

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Director

Funeral

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Completed

Funeral

Director

permit. Peges 1 end 2 should be filed within 72 hours efter death with the Meryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "naturs!", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examinat must be notified at once.

Baltimore, Maryland 21215-0020

Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseasa or injury that initiated events resulting in deeth) Last Physician/Medical

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Wes case referred to medical axaminer? 1 Yes 2 No 27. Menner of Death 1 Neturel

5 Pending investigation 2 Accident 6 Could not be determined 3 Sulcide 4 Homicide

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 28b. Time of

28e. Pleca of Injury - At home, term, street, lactory, office building, etc. (Specify)

Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 28c. Injury et Work? 1 Yes 2 No

26. Pleca of Death (Check only one)

28l. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Road Eldersburg Maryland 21784

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medicat Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and menner stated. 29b. Signeture and title or carlifier

29c. Licanse number D34849

29d. Deta signed (Month, Day, Year) August 26, 1997

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

-MD

William Tan MD

1645 Liberty Ficker Position Signe Mendo M

State Registrar OCME

Penn Street, Baltimore, Maryland 21201

cause of deeth (Item 23e) (Type, Print)

AUGUST 30,1997

State Registrar

SEP 0 8

30. Name and address of person who come

111

Ann Dixon M.D.

DHMH 16 Rev 6/95

97-4655-510

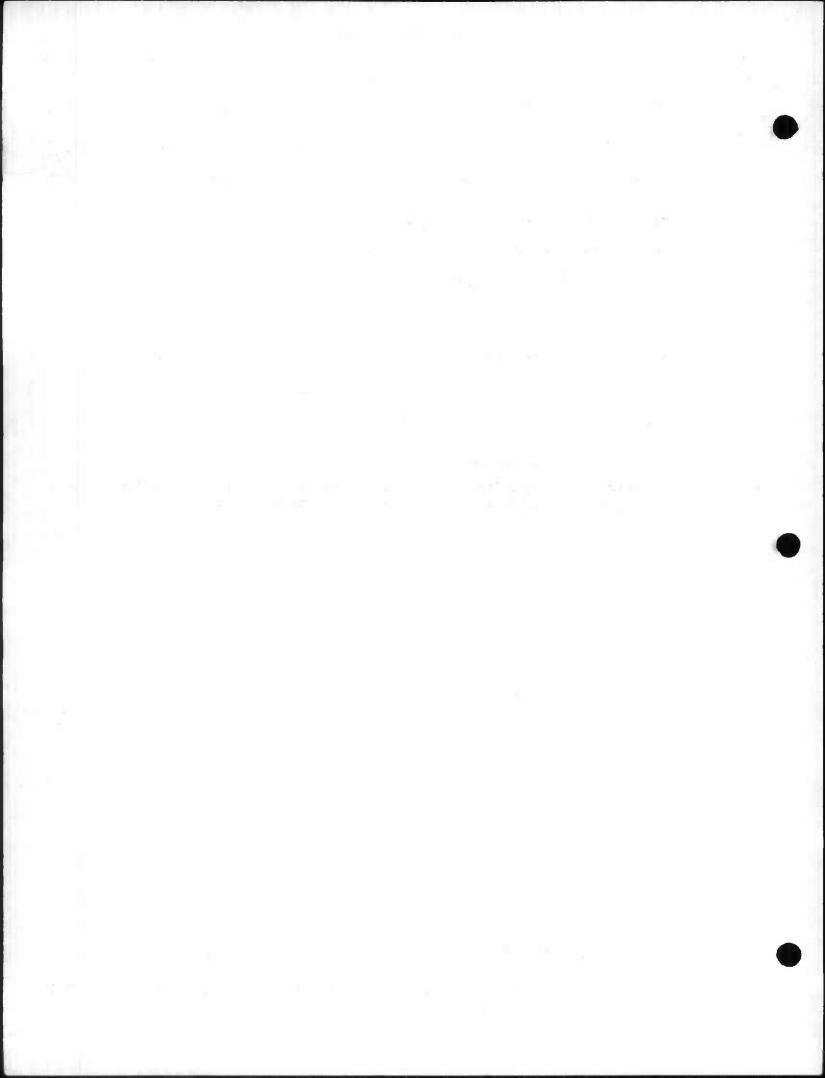
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State of Maryland / Department of Health and Mental Hygiene 97 27278

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| Heelth and Mentel Hygiene. Items 27 is marked other than "natural", or items 23s or 28s-1 show Language and the standard Examines must be noticed as a contract of the standard other traumatic event, the Madical Examines must be noticed as a contract of the standard of | 4e 9 5. Us 10 10 11 11 11 11 11 11 11 11 11 11 11 | 22 N • CALVERT Social Security Number unknown suel Residence of Decedent Da. Stete 10b. County | Bonsall give street and numb STREET 6. Sex 15kM 2 F u moreCity t Street wn 12. Was Decede Armed Force of Lambda Force | Age (In yrs. nknown 10c. Cit Ba. nt Ever in U s? unkn | y, Town or Location Ltimore S. Own 13. Was Own | Under 1 Year lonths Deys | 4b. City, Town, or L BALTIMO If Under 24 Hrs. Hours Min. | | Day 18 1 4c. County Balt: | Year 997 10 of Deeth imore C 9. Birthplace Country) unknown 10d. Ir | (State or Foreign |
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| nd Mentel Hygiene. marked other than "natural", or liema 23s or 28s-f show and imate ovent, the Medical Examines must be nothered at one of the To Be Completed by Funeral Director | 9 5. 10 10 11 | Social Security Number unknown suel Residence of Decedent Da. Stete 10b. County Maryland Balti Da. Street end Number 922 N. Calver Marital Status 1 Never Merried 1 Never Merried 15. Decedent (Specify only highes Elementery/Secondary (0-12) unknown Fether's Neme (First, Middle, 15) | STREET 6. Sex 10 M 2 F .moreCity t Street wn 12. Was Decede Armed Force 1 Yes, Give Year or Date s Education tyrade completed) College (1-4) | Age (In yrs. nknown 10c. Cit Ba. nt Ever in U s? unkn | y, Town or Location Ltimore S. Own 13. Was Own | On Deys On Control of Europe Code 21202 Decedent of the Code Code Code Code Code Code Code Cod | BALTIMO If Under 24 Hrs. Hours Min. | RE 8. Dete of Bin (Month, Da | Balt: | 9. Birthplace Country) unknow 10d. Ir | (Stete or Foreign |
| nd Mentel Hygiene. marked other than "natural", or itema 23a or 28a-f show an immatic event, the Medical Examination must be nothered at the To Be Completed by Funeral Director | 5. Us 100 I | Social Security Number unknown suel Residence of Decedent Decedent Decedent Decedent Decedent Decedent Decedent Decedent Specify only highes Elementery/Secondary (0-12) unknown Fether's Neme (First, Middle, 150) Eunknown Unknown Elementery Secondary (1-12) Unknown Elementery Secondary (1-12) Elementery Secondary (1-12) Elementery Secondary (1-12) Unknown Elementery Secondary (1-12) Elementery Secondary (1-12) Unknown Elementery Secondary (1-12) Elementery Secondary (1-12) Elementery Secondary (1-12) Elementery Secondary (1-12) Elementery Secondary (1-12) Elementery Secondary (1-12) Elementery Secondary (1-12) Elementery Secondary (1-12) Elementery Secondary (1-12) | 6. Sex 7. 15th 2 F U moreCity t Street wn 12. Was Decede Armed Force of I Yes, Give Year or Date S Education tyrade completed) College (1-4) | nknown 10c. Cit Bal | y, Town or Location Ltimore S. Own 13. Was Own | on 10f. Zip Code 21202 | If Under 24 Hrs. Hours Min. | 8. Dete of Bir (Month, Da | th y, Year) VD 10g. Citizen of V | 9. Birthplace Country) unknow 10d. ir 1. Whet Country? | (State or Foreign |
| nd Mentel Hygiene. marked other than "natural", or itema 23a or 28a-f show an immatic event, the Medical Examination must be nothered at the To Be Completed by Funeral Director | 100 N 100 111 111 111 111 111 111 111 11 | unknown suel Residence of Decedent De. Stete 10b. County Maryland Balti De. Street end Number 922 N. Calver Marital Status unknoum 1 Never Merried 2 Marria 3 Widowed 4 Divorced (Specify only highes Elementery/Secondary (0-12) unknown Fether's Neme (First, Middle, 12) | moreCity t Street 12. Was Decede Armed Force of 1 Yes 2 If Yes, Give Year or Date 3 5 5 5 5 S Education tyrade completed) College (1-4) | nknown 10c. Cit Bal | y, Town or Location Ltimore S. Own 13. Was Own | on 10f. Zip Code 21202 | Hours Min. | | 10g. Citizen of V | 10d. ir | nside City Limits |
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| t and Mentel Hygiene Is marked other tha raumatic event, the To Be Com | 17 | unknown Fether's Neme (First, Middle, I | | | 16a. Decedent' (Give kind life. DO I | 's Usuel Occup d of work done NOT use retire | petion during most of work d) | ing | 16b. Kind of Bu | usiness/Industry | |
| s and Mentel Hy Is marked other reumatic event | 17 | | | or 5+) | unkno | wn | | | unknov | wn | |
| Is marked raumatica | | unknown | Last) | | | | 18. Mother's Nem | e (First, Middle, | Meiden Sumem | ne) | |
| Is and | 19 | | | | | | unknown | | | | |
| Heelth am 27 other tr | | e. informent's Neme/Reletions unknown | nip (Type, Print) | | 19b. Meiling A | | end Number or Rui | al Route Number | er, City or Town, | Stete, Zip Code |) |
| Department of Heelth at Important: if itam 27 is any Injury or other treuonce. | 20 | e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (Sp | | te | Plece of Disposition emetery, cremeto | | ce) | Date | 20c. Location - | City or Town, S | itete |
| Depart Importu any Inj | 21 | Signature of Funeral Service (| Wade Di | ector | | | ss of Fecility tomy Boar Marylan | | W. Balt | imore S | reet |
| n and hiel-transit and Examiner | di | nmediete Ceuse (Finel sease or condition sulting in deeth) | e. FATTY | Due to (o | AND ALCOHOL | ce of): | TITIS | | | | |
| nding physicie use as the bur n/Medical | the | equentielly list conditions, eny, leeding to Immediate use. Enter Underlying ause (Disease or Injury et initieted events sulting in deeth) Lest | c | Due to (or es e consequence of): | | | | | | | |
| the atte | Pe | rt II. Other significant condition | ns contributing to death | but not resu | uiting in the under | lying cause giv | ren in Pert I. | 23b. Did 1 | obacco use cor | ntribute to the | cause of death? |
| igned by the be deteched by Physic | | | | | | | | 1 🗆 | Yes 2□No | 3 Probably | 4 Punknow |
| 2 should | _ | | | | | | | | en autopsy med? | aveileble | topsy findings e prior to ion of ceuse ? |
| cate he | | | | | | | | 12 | res 2 No | 1 XYes | 2 No |
| certificate irector, par | 25 | . Wes case referred to medical exeminer? | Hospital | | | 011 | 26. Piece of Deel | h (Check only o | ne) | | |
| Plant di | 27 | 1 X Yes 2 □ No . Manner of Deeth | Hospitel: 1 Inpe | | | DOA Oth | 4 U Nursing Ho | | dence 6 Oth | | |
| al Director: After the in by the funeral Certification: | 27 | 1A2 Netural 5 Pending 2 Accident investig 3 Suicide 6 Could n |) (Month, i | Dey Year) | 28b. Time of Injury | 28c. Injur Wor M 1 □ | y et k? Yes 2 □ No | 28d. Describe r | now injury occurr | red | |
| urs effer death | | 4 Homicide determi | ned 286. Piece of | Injury - At ho etc. <i>(Specif</i>) | me, farm, street, t | factory, office | | 281. Location (S City or Tov | Street end Numb vn, Stete) | er or Rural Rou | e Number, |
| within 24 hours e To the Funeral D completely filled Medical Ce | 29 | e. Certifier 1☐ Certifying (Check only one) 1☐ Certifying 2☒ Madical E | Physician: To the be- examiner: On the basis end menner | of examinet | wiedge, deeth occion and/or investig | curred et the tir getion, in my o | ne, date end piece, pinion, deeth occur | end due to the red et the time, | ceuse(s) end me dete end place, o | enner as stated. end due to the d | ause(s) |
| Toth | 29 | b. Signature and title of certifier | , 11 | | | 29c. Licens | e number | | 29d. Dete signed | d (Month, Dey, | (ear) |
| | 30 | Neme end eddress of person v | M. K. | good / | 230) (Tune De' | O.C. | M.E. | A | UGUST | 19,199 | 7 |

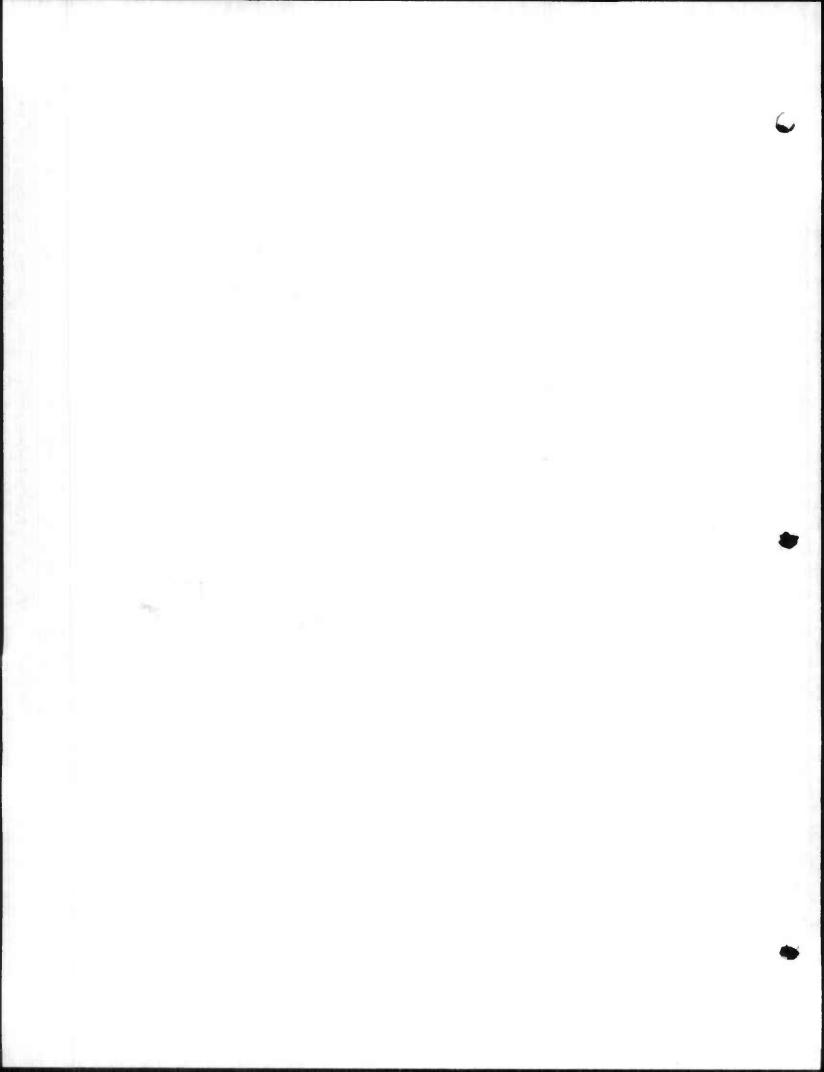
Registrar



MISSING

DEATH

certificate no.: 97-27278



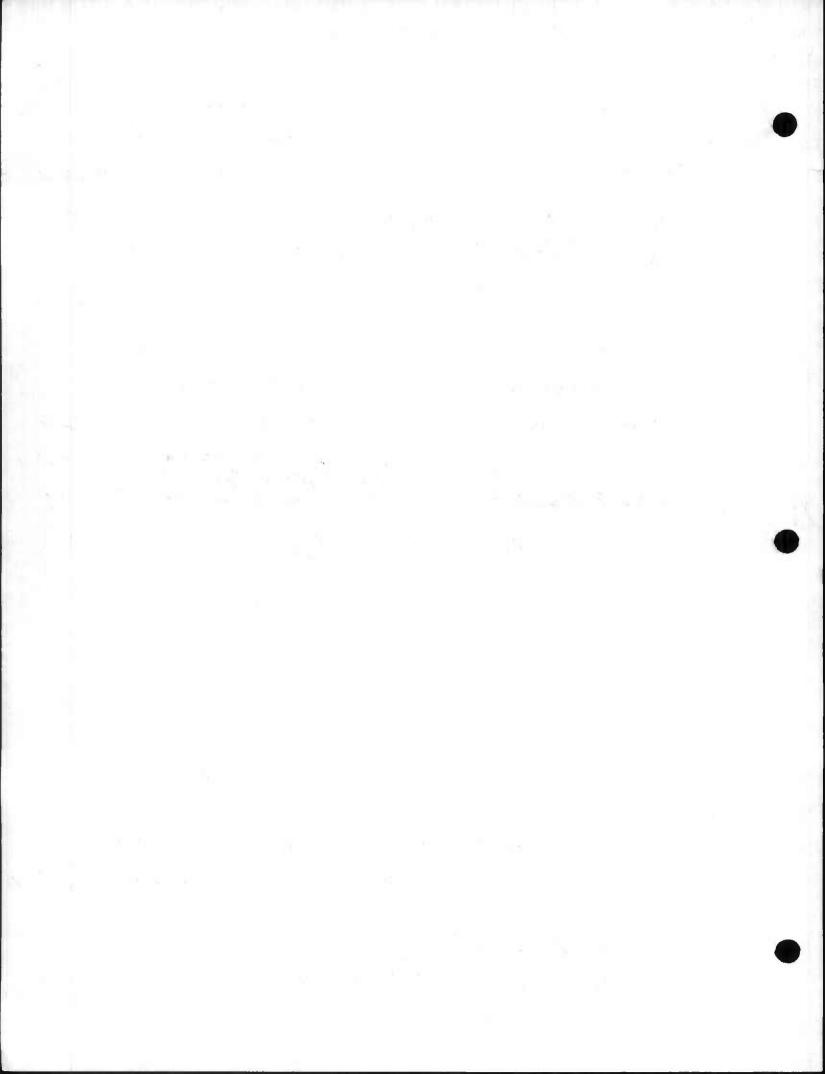
State of Maryland / Department of Health and Mental Hygiene

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|---|---|---|-----|---|---|---|---|
| |) | 1 | Com | 1 | 6 | 1 | |

| R | | | | State of Mary | | ertificate d | | | Reg. No. | 12 | 1279 |
|---------------------|--|--------------------|---|--|---------------------------------|--|---|---|-----------------------------|---|--|
| | Physic /Medi Exami | cal | 1. Decedent's Neme (First, Middle, L. TERESA 4a. Facility Neme (It not institution, gi | KR | | | 4b. City, Town, o | 2. Dete of De Month AUGUS' r Location of Deeth | Day | Yeer 997 2 | Time of Deeth |
| | Funeral Director | | | | yrs, lest birthda Yrs. | Months De | | s. 8. Date of Birt | y. Year) 5 1 | 9. Birthplace | (State or Foreign |
| | Maryland H show | tor | 10a. Stete 10b. County | 4 | City, Town or | Location TompRE | L | | | | aside City Limits |
| | death with the Maryland ms 23a or 28a-f show rmst be notified at | al Director | 10e. Street and Number | LASKI STI | 77.00 | 10f. Zip Cod | 12-1/1 | | 10g. Citizen of 1 | Whet Country? | |
| 020 | | by Funeral | 11. Merifal Stafus 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Wes Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Defes: | in U,S. 1 | 3. Was Decedent of Yes, specify C | of Hispenic Origin? (Cuban, Mexican, Pue No Specify: | Specify Yes or No into Rican, etc.) | - 14. Rac Ble Specifi | e - American inck, White, etc. | dien, |
| Maryland 21215-0020 | ied within 72 hours efter ygjene. Nor then "neturel", or fte ft, tre Medical Exemen | Completed | 15. Decedent's E (Specify only highest gr Elementery/Secondary, (0-12) | ducation ede completed) College (1-4or 5+) | (Gi | cedent's Usuel Oc ve kind of work do b. DO NOT use re | ne during most of w | orking | 16b. Kind of B | usiness/Industry | |
| yland | tal H out | To Be C | 17. Father's Neme (First, Middle, Last ABRMAN RA) | 165M | | | 719A | ame (First, Middle, ARAA | 55M | | |
| | Baltimore, Marylk permit. Pages 1 end 2 should Department of the leit and Mer Important: if them 27 is marke any injury or other traumatic any injury or other traumatic | | 19e. Informent's Name/Relationship A G N 20e. Method of Disposition | R | 400 | DELIVER PROPERTY OF STATE OF THE PROPERTY OF STATE OF STA | 75/41RE | Pural Route Number | DALI | State, Zip Code 1997, 2 City or Town, S | 127/ |
| altimo | | | 1 ☑ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Special Signature of Funeral Service Lical Ser | fy) | V05/9 | 22 Namand Ad | piace) (197) (199) (199) (199) (199) (199) | 8/22/97 4 Fungs | BALTI | MORE P.A | MP, |
|) | | | 23a. Rant 1 Enter the disease, of con shorts, of heart failure. List only | plicetions thet caused the cone ceuse on each line. | deeth. Do not e | 2707 enter the mode of | REDAIL dying, such es cardi | ON PASS ac or respiratory a | BALT, | Inter | 1229 roximete vel Between |
| | | | Immediate Cause (Final disease or condition resulting in death) | · Jousto | t Wa | ed y | heet | | | Ons | ef and Death |
| Box 68760, | eath certificate be executed ettending physicien and for use as the buriel-transit | n/Medical Examiner | Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest | b. Due t | to (or as a cons | sequence of): | | | | | |
| P.O. | t the d | Physician/M | Pert II. Other significant conditions | contributing to deeth but not | resulting In the | underlying cause | given in Pert I. | | lobacco use co Yes 2 No | ntribute to the | cause of death? |
| Records, | aw requires s been sign 2 should be | Completed by | | | | | | 24a. Was perio | an autopsy med? | available | utopsy tindings a prior to ion of cause ? |
| of Vital B | sician: The certificate rector, pe | To Be Con | 25. Wes case referred to medical exeminer? | Hospifal: 1 ☐ Inpatient | eff f D/Output | ient 3□ DOA | Othor: | eath (Check only of Home 5 Resid | | 1 Xyes | 2 No |
| Division of | 0 0 2 | Certification: T | 27. Menner of Death 1 Neturel 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be | 28e. Dete of Injury (Month, Day Year of \$1(819) | 28b. Time Injury 2 / / | of 28c. in | njury et Work? I Pes 2 No | 28d. Describe I | now injury occur | red | 4. 81 |
| Divi | To the Hospital or Attendin within 24 hours effer death. To the Funeral Director: Aft completely filled in by the fur | | 29a. Certifier 1 Certifying Pr | building, etc. (Sp | vecify) VLM knowledge, de | | e time, dete end ple | City of Tov | cause(s) and mi | | Mulasks' |
| | To the H within 24 To the Fu | Medical | 29b. Signeture end title of certifier | niner: On the besis of exercend menner stated. | ms | 29c. Lic | ny opinion, death occ ense number CME | | 29d. Date signe | end due to the old (Month, Day, | Year) |
| | | | 30. Name end eddress of person who | completed cause of deeth | 111 111 | e, Print) Penn S | treet, E | altimor | e, Mar | yland | 21201 |

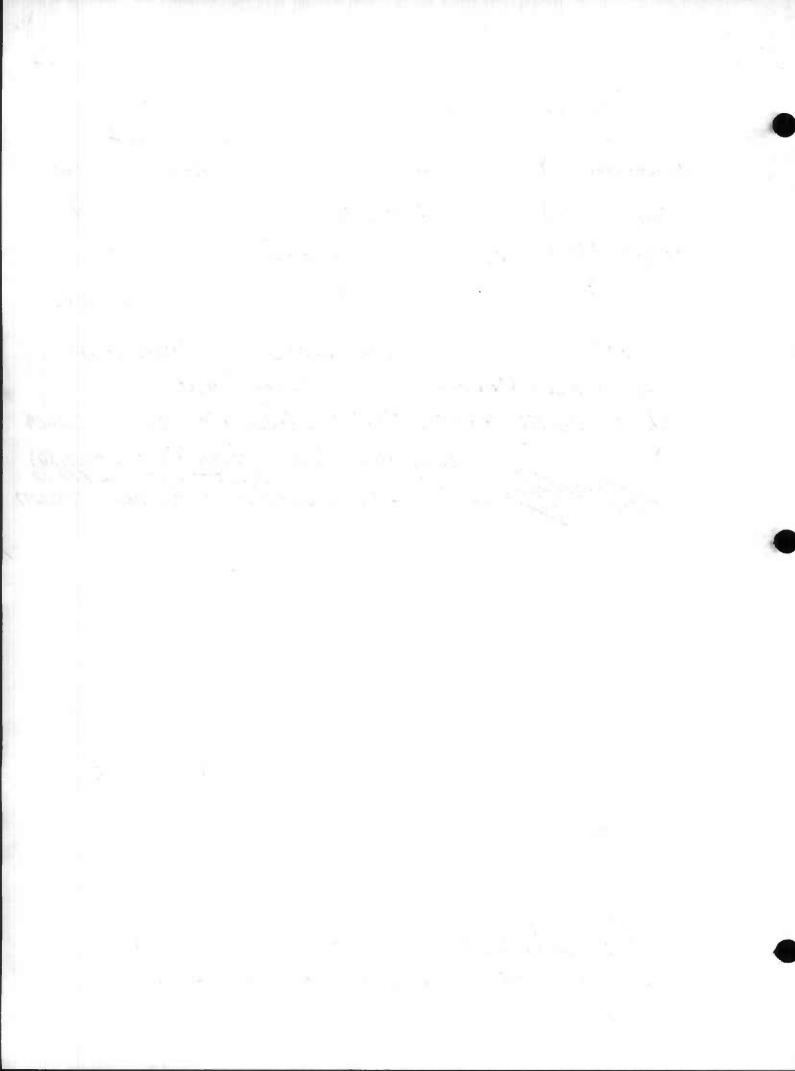
State Registrar 31. Dete filed (Month, Day, Year)

32. Registrer's Signeture



| CARROLL COXSON _{Ite} | me • 2 | 23a part I,27,28a-f per M | State of Marylan | d / Departmer | t of Health and e of Death | | 2 | 7 27 | 280 |
|--|------------------|---|---|-------------------------------|--|--|------------------------------|---|--|
| Physic | | 1. Decedent's Nama (First, Middle, Last) | 1 | 2 | 0.00000 | 2. Data of De Month | Day | Year | me of Death |
| /Med Exam | lical | 4a. Facility Name (If not institution, give s | treet and number) | // | 4b. City, Town, or | SEPT. | 06, 199 | | 40 PM. |
| SAUTT OF THE PROPERTY OF THE P | | ST. AGNES HOSPI | | | | IMORE | / | VA | |
| Funera Directo | _ | 5. Social Security Number 3.10-64-3731 Usual Rasidence of Decedent | M 2□ F | Ast birthday) If Under Months | 1 Year If Undar 24 Hrs Days Hours Min | | 153 | 9. Birthplace (5 Country) | tate or Foreign |
| death with the Maryland ms 23a or 28a-f show | tor | 10a. State 10b. County MD NA | 10c. City | BALTIN | IORE | | | | ide/City Limits |
| th with the 23s or 28 | Funeral Director | 10e. Street and Number Delay | vare a | 101. Zip | 21215 | | 10g. Citizen of V | What Country? | |
| 020 ours after al', or its | by | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorcad | 2. Was Decedent Ever in U, Armed Forces? 1 ☐ Yas 2 No If Yes, Give Year or Datas: | S. 13. Was Deceif Yes, spe | dent of Hispanic Origin? (to cify Cuban, Mexican, Puer 2 No Specify: | Specify Yes or No to Rican, etc.) | 14. Race Blace Specify | BlAC | an, |
| nd 21215-0020 a filed within 72 hours af al Hygiene. other than "natural", or | Completed | 15. Decadent's Educ (Specify only highest grade Elementary/Secondary (0-12) | ation com <i>pleted)</i> College (1-4or 5+) | life. DO NOT u | rk done during most of wo | orking | 16b. Kind of Bu Auto | SHOP |) |
| aryland 2 should be filed and Mental Hygie s marked other | To Be | 17. Father's Name (First, Middle, Lest) Lawkence | Coxpor | 7 | 18. Mother's Na | me (First, Middle, | ith | | |
| Baltimore, Maryland 21215-0 permit. Pages 1 and 2 should be filled within 72 h Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural any injury or other traumatic event, its Medical | | 20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funaral Service Licania 23. Part Criter the disease or corporate shock, or heart failure. List any on | emoval from State | 638 | Paul Paul id Address of Facility N. Gilm | Date 9/12/97 13-FT 05 57. c or raspiratory a | Rand P. W. | Interv | T, MI) H-A ID2/21, iximata el Between |
| Physician /Medical Examiner | | Immediate Cause (Final disease or condition rasulting in death) a. | COCAINE INTOXIC | ATION COMPLIC | ATING PULMONAR | Y EMBOLI | | Olise | and Death |
| 58760, icate be executed physician and s the bunal-transit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or | as a consequence of): | | | | 1 | |
| x 68760, sertificate be extended by the physician are as the burial. | Medicai | Cause (Disease or injury thet initiated events rasulting in death) Last | Due to (or | as a consequence of): | | | | | |
| cords, P.O. Box 6 requires that the death certific teen signed by the attending phould be detached for use as | by Physician/M | Part II. Other significant conditions cont | ributing to death but not resu | liting in the underlying o | ause given in Part I. | | tobacco use cor Yes 2□ No | ntribute to the co | Suse of death? |
| 2 8 8 | Completed t | | | | | | an autopsy rmed? | 24b. Were autevallable completion of death? | |
| | e Cor | 25. Wes case referred to medical | | | 00.51 (5 | - 0 | Yes 2□No | Yes | 2□ No |
| Of Vita Physician: rithis certific and director, | To B | examiner? | ospital: 1 ☐ Inpatient 2🖔 | ER/Outpatient 3 D0 | Other | ath (Check only of Home 5 Rasio | | er (Specify) | |
| E & \$1 | | 27. Manner of Death 1 □ Natural | 28a. Data of injury (Month, Day Yaar) | | Bc. Injury at Work? | 28d. Describe | now injury occurr | ed | |
| or Attending of Attending offer death. Director: After in by the fune | ficat | 2 Accident Investigation 3 Suicide 6XXCould not be determined | 9/6/97 28e. Placa of Injury - At ho | unknown M | 1 ☐ Yas 2)(C)(No | unknown 28f. Location (S | Street and Numb | er or Rural Route | Number, |
| Div | Certification: | 4 Homicide | building, etc. (Specify | | ,, 5,,,,, | Baltimore | vn. State) 42 S | wann Ave. | , |
| Division To the Hospital or Attendiwithin 24 hours effer death. To the Funeral Director: A completely filled in by the funeral | edical | | cian: To the best of my know er: On the basis of axaminat and menner steted. | | | | | | iuse(s) |
| To the To the Comp | W | 29b. Signature and title of certifier | onhell | 296 | O.C.M.E. | | 29d. Data signed SEPT . 0 | (Month, Day, Y | ear) |
| Si | ate | 30, Name and address of person who cor J-LA-FCSH CO CCE 31. Date filed (Month, Dey, Year) | npleted cause of deeth (Item 1) 32. Registrar's Signal | 1 Penn Str | eet, Baltim | ore, Mary | yland 21 | 201 | |

Registrar SEP 0 9 1997 Julia Saudson Rendalle



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Items10b,10e 9-9-97 Film6751 W.H.Per F/H Certificate of Death 1. Decedant's Neme (First Middle Last) 3. Time of Deeth 2. Dete of Daath **Physician** Septenser (o
4b. City, Town, or Location of Deeth 4c. Coun Cherkno /Medical 4c. County of Death Facility Name (If not institution, Examiner Baltinou Baltimore Gulchrist Center rsClast birthday) If Under 1 Year HOSPILE 0 If Undar 24 Hrs. 8. Dete of Birth (Month, Day) 5. Sociel Security Number 7. Age (In yrs ast birthday) Birthpleca (State or Foreign Country) **Funerai** Deys 1 ☐ M 2 🔀 F 122-14-0350 Yrs. 71 Director NEW YORK Usuel Rasidence of Decadent the Maryland 10b. County Fairfax 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 1□Yes 2□No Director 28a-f **VIRGINIA** FALLS CHURCH FALLS CHURCH 10e. Street end Number 1011 10f. Zip Code 10g. Citizen of Whet Country? must be r 101 HILLWOOD AVE. 22042 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Dacedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. Rece - American Indien. I ☐ Yes 2 ☐ No If Yas, Give 1 Never Merried 2 Married 10 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) 5+GERIATRIC COUNSELING SOCIAL SERVICES 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Meiden Surname) Be JOSEPH ROSENBERG **ESTHER** RIEMER Mary Pages 1 and 2 shou 19e. Informent's Neme/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) . Health I MICHAEL CHECKNOFF (SON) 616 ANNESLIE RD. BALTO., MD 21212 altimore, 20b. Place of Disposition (Name of cemetery, cremetory or other pleca) 20e. Mathod of Disposition 20c. Location - City or Town, Stete Dete Department of Important: If is any injury or o ъ 1 NBurial 2 ☐ Cremation 3 PRemovel from Stete 4 ☐ Donation 5 ☐ Othar (Specify) 9-8-1997 PINELAWN, L.I., N.Y. WELLWOOD 22. Nama and Address of Fecility
Sol Levinson & Bros., Inc. 21. Signeture of Funarel Servica Licansee Dermoor 8900 Reisterstown Road Pikesville, MD 21208 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or raspiretory arrest, shock, or heart feilure. List only one cause on each line. Interval Between Onsat and Death **Physician** /Medical Immadiete Ceuse (Finel ears disease or condition resulting in deeth) Examiner Dua to (or as e consequence of) The law requires that the death cartificate be executed **burial-transi** Sequantielly list conditions, if eny, teading to Immediate ceuse. Enter Undarlying Ceuse (Disaese or Injury that initieted events resulting in daeth) Last Dua to (or as a consequence of) Physician/Medicai the Due to (or es a consequenca of) use as Pert II. Other algnificant conditions contributing to deeth but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 8 24b. Were eutopsy findings avelleble prior to complation of causa of daath? page 2 should Completed 24a. Was en eutopsy 1 ☐ Yas 2 No certificate 1 ☐ Yes 2 ☐ No Attending Physician: director, 25. Wes cesa referred to medicat Be 26. Pleca of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hogsice Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No 2 this funeral 28a. Date of tnjury (Month, Day Year) 27. Mennar of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? After 1 Naturel 2 ☐ Accident 5 Pending invastigation death. 1 ☐ Yes 2 ☐ No None efter death in by the 3 Sulcide 6 Could not be datarmined 28e. Placa of Injury - At home, ferm, straet, fectory, offica building, atc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours of To the Funeral Completely filled Hospital 29a, Certifier **Certifying Physician: To tha best of my knowledge, daath occurred et the time, dete end pleca, end due to tha ceusa(s) and manner as steted.

2 Medical Examinar: On the basis of examination end/or investigetion, in my opinion, death occurred et tha tima, data end place, and due to the cause(s) end manner steted. Medicai 29b. Signature and tipe of perfitter 29c. License number 29d. Dete signed (Month, Dey, Year) , mo causa of daath (m 23a) (Type, Print)

P.O. |

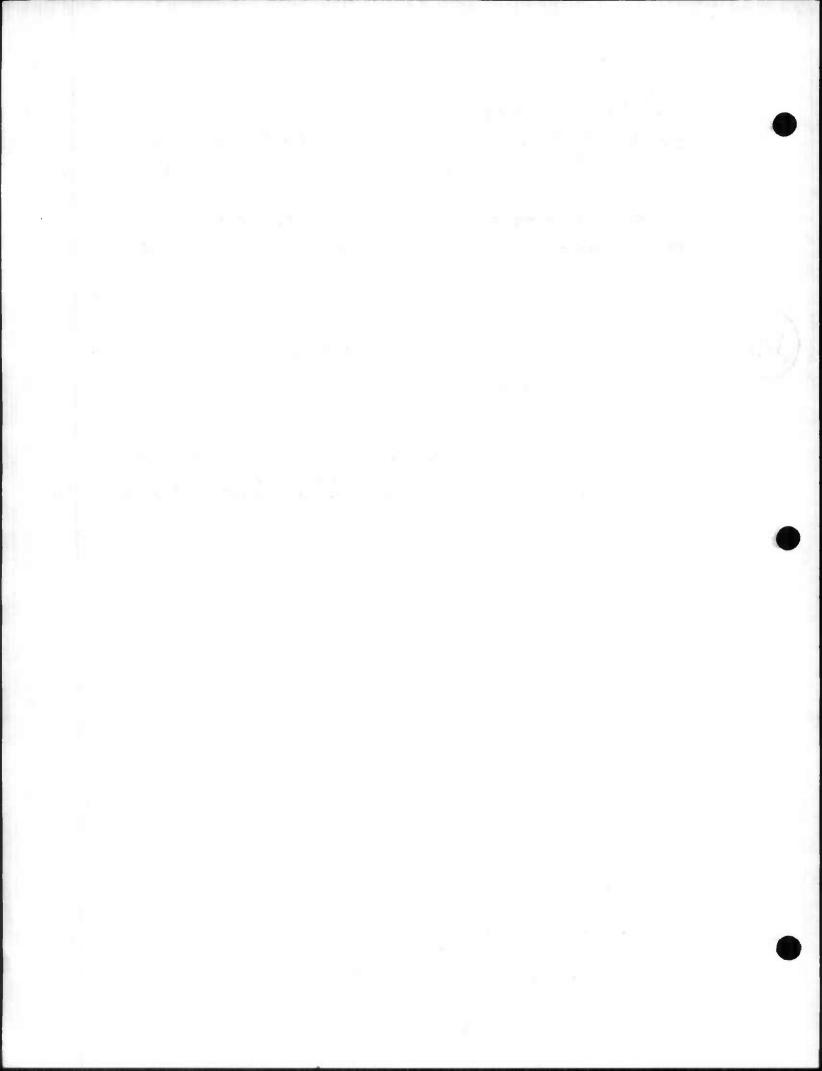
Vital

of

Division

State Registrar

Charles St. Balto



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

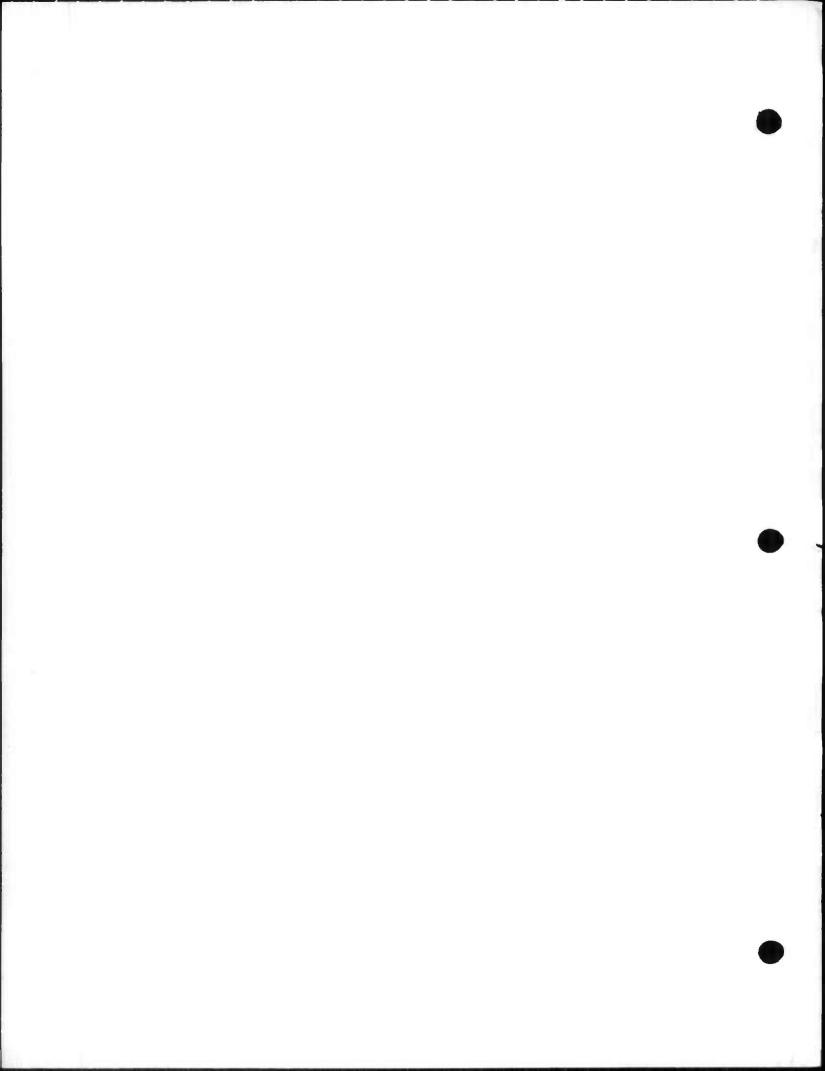
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to bunal, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL | HYGIENE |
|---|----------|
| CERTIFICATE OF DEATH | REG. NO. |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYLA | ND / DEPARTM | IENT OF H | EALTH AND | MENTAL HYGIEN | | 1 61606 |
|------------------|--|---|---|--|--------------------|--|-----------------|--|
| | 1. DECEOENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF CEATH |
| | Robert | Crue | | | | AUTUST TE | | AR 1130 A M |
| | 4. SOCIAL SECURITY HUMBER 5. | SEX 6. AGE (in | | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8. 6 | BIRTHPLACE (State or Foreign |
| | | RM2□F 69 | YRS. | NTHS DAYS | HOURS MIN. | July 11, | | aryland |
| | 9a. FACILITY NAME (If not institution, give street | and number) | 96 | CITY, TOWN O | R LOCATION OF OR | | 9c. COUNTY | |
| DIRECTOR | 4291 Falls Road | | | Baltim | ore | | Balti: | more City |
| ט | RESIDENCE OF DECEDENT | | | | | | | |
| E | | | 500 | OWN OR LOCAT | ОН | | | 10d. JHSIDE CITY LIMITS? |
| ٥ | Maryland Baltim | nore City | Balti | | | | | t 🖾 YES 2 🗌 NO |
| RA | 4291 Falls Road | | | 101. | ZIP CODE | | | OF WHAT COUNTRY? |
| FUNERAL | | W. 6 | | | 21211 | | U.S. | |
| | 1 Never Married 2 Narried | FORCES? 1 YES | 2 XNO | If yes, spe | city Cuban, Mexica | IIC ORIGIN? (Specify Yes n, Puerto Rican, etc.) | or No- 14. | RACE — American Indian, Black, White, etc. |
| ВУ | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DAT | res | 1 TES | 2 NO Specify | y: | | SpecMy: White |
| G | 15. DECEDENT'S EDUCATION | ON | 16a. DECEDENT'S USU | IAL OCCUPATIO | N | 16b. KIHD OF BUS | IHESS/INDUST | BY |
| | (Specify only highest grade com Elementary/Secondary (0-12) | college (1-4 or 5 +) | (Give kind of work life. Do NOT use re | done during mos tired.) | t of working | | | |
| <u>a</u> | 12 | | Electri | cian | | Pri | vate | |
| COMPLETED | 17. FATHER'S HAME (First, Middle, Lest) | | | CZGII | 16. MOTHER'S HA | ME (First, Middle, Meiden | Sumame) | |
| BE (| John Benjamin Cru | e | | | Margar | et Ellen G | aunt | |
| 6 | 19e. IHFORMANT'S NAME (Type/Print) | - | | | | Route Number, City or Town | | |
| F | Betty Crue/wife | | 4291 F | alls R | oad, Bal | timore, Ma | ryland | 21211 |
| | 20e, METHOD OF OISPOSITION 1 | | PLACE AND DATE OF O | | ne of | DATE 20c. LOC | CATION — City | or Town, State |
| | 4 Donation 5 Other (Specify) | | | | | | | |
| | 21. SIGNATURE OF FUHERAL SERVICE LICENS Ronald | S. Wade, Di | rector | Stat | e Anatom | y Board, 6 | 55 W. | Baltimore St. |
| | John John J | Miller | | Balt | imore, M | laryland 21 | 201 | |
| ŀ | 23. PART I/Enter the diseasea, or com ahock, or heart failure. List | plications that caused to only one ceuse on ear | the deeth. Do not o | enter the mod | le of dying, suci | h as cardiac or respir | ratory arrest, | Approximate Interval Between |
| | IMMEDIATE CAUSE (Final disease or condition | | | | | 1 | | Onset and Death |
| | resulting in death) e | | meto. | static | (a) - | unknown | brim | ay year |
| | | DUE TO (OR AS A C | CONSEQUENCE OF): | | | | A | |
| o I | Sequentielly list conditions, b. — | DUE TO (OR AS A (| CONSEQUENCE OF: | | | | | |
| Ä | if any, leading to immediate cause. Enter UNDERLYING | | | | | | | |
| Ē | cause (Disease or injury that initiated eventa | DUE TO (OR AS A (| CONSEQUENCE OF): | | | | | |
| CERTIFICATION | reaulting in deeth) LAST | | | | | | | |
| | PART II. Other aignificent conditions co | ontributing to death bu | t mot seculting in th | and the second s | Washington, ed. | | | |
| SAL | The state argument conditions of | Antibuting to death but | t not resulting in th | e underlying | cause given in | Part I. 24a. WAS AN / PERFORI | | 24b. WERE AUTOPSY FINDINGS AMAJLABLE PRIOR TO |
| | | | | | | 1 TYES Z | NO | OF DEATH? |
| Σ | DID TORACCO LICE CONTROLS | | | <u> </u> | | | | 1 TYES 2 HO |
| AN | DID TOBACCO USE CONTRIBI | | B. PLACE OF DEATH (C | | UNCERTAIN | 1 23 1 | | |
| S | EXAMINER? | OSPITAL: | ОТ | HER: | | | | |
| PHYSICIAN: MEDIC | 27. MAHNER OF OEATH | Inpatient 2 ER/Outpat | 28b. TIME OF | | | 6 Other (Specify) | | |
| | 1 Natural 5 Pending | (Month, Day, Year) | IHJURY | WOF | | 28d. DEŞCRIBE HOW IH | JUNY OCCURE | |
| BY | 2 Accident Investigation 3 Suicide 6 Could not be | 28a. PLACE OF INJURY - | - At home, farm, street | | | 281. LOCATION (Street of | nd Number or Ru | ural Route Number |
| COMPLETED | 4 Homicide determined | building, etc. (Specify | 1) | | | City or Town, Stete) | | , |
| ٦ ا | 29e. CERTIFIER (Check only | : To the best of my knowler | doe death occurred at | the time data | and place, and due | to the country and are | and the | |
| Š | one) 2 MEDICAL EXAMINER: Or | | | | | | | special and manner as stated |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICEHSE NUM | | | |
| B | 4 | 1 | | | DZ- | 1573 | MILE SIG | NED (Month, Day, Year) |
| 임 | 30. HAME AND AGORESS OF PERSON WHO CO | MPLETED CAUSE OF DEAT | | | VS | <u> </u> | NU | 1001 00/11/1 |
| | Sof Ribell | MD 727 | | k He | a dur | ve. Batt | nae) | 80515 am |
| | 31. DATE FILED (Month, Day, Year) | 02 REGISTRAR'S SIGNAT | URE | | 7 | | | |
| | SEP 0 8 1997 | wha Davidson-V | andre | | | | | |
| | | | | | | | | |



Funeral

Director

ral', or items 23a or 28a-f show Examiner must be notified at

the Maryland

with

should be filed within 72 hours efter on the Mental Hygiene.

marked other than "natural", or item

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked othe any Injury or other trauments

traumatic event, the Madical

Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2 Date of Death 3. Time of Death Month Year **Physician** AUG. 23, 1997 Cornelius Cromer 1015 AM /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1529 WEST 36TH STREET BALTIMORE Baltimore City 5. Social Sacurity Numbar If Undar 1 Year If Under 24 Hrs. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) 1 № M 2 🗆 F Months Days Hours Yrs. 212-26-5835 Jan 11, 1929 unknown 68 Usual Rasidanca of Decadant 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits 1√ Yes 2 No Director Maryland Baltimore City Baltimore 10a, Street and Number 10f. Zip Code 10g. Citizan of What Country? 1529 W. 36th Street 21218 U.S.A. Funeral 11. Marital Statusunknown 12. Was Dacedent Ever in U.S. Armed Forcas? unknown Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) Race - American Indian, Black, Whita, atc. 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 ☑ No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nema (First, Middla, Maidan Sumama) Be unknown unknown 2 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stata, Zip Code) unknown 20b. Placa of Disposition (Nema of camatary, cramatory or other placa) 20a, Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burlal 2 ☐ Cramation 3 ☐ Ramoval from Stata 4□Donation 5员Other (Specify) in State 22. Name and Addrass of Facility Brard, 655 W. Baltimore Street Wade, Director Baltimore, Maryland 21201 Furth. Entar tha diseasa, or complications that caused tha daath. Do not anter tha moda of dying, such as cerdiac or raspiratory arrast, block, or heer failura. List only one cause on each lina. Approximata Interval Batween Onset and Death Immediate Ceuse (Final diseasa or condition rasulting in daath) a Arteriosclerotic Cardiovascular Disease Dua to (or as a consequence of):

Physician /Medical Examiner

physician and s the buriel-transit

98 Se for

the signed by

this

Ne Hospital or Attending Pl in 24 hours effer death. The Funeral Director: Affer to betelv filled in by the funeral

within 2 To the

Box 68760.

Division of Vital Records, P.O.

that the death certificate be

Examiner Physician/Medical ģ Completed Be To C Certification: Sequantially list conditions, if any, laading to Immadieta ceuse. Enter Undarfying Cousa (Disaasa or Injury thet Initiated events rasulting in daath) Last

Dua to (or as a consequence of): Dua to (or as a consequence of):

| | d | | | | | 1 |
|--|--|------------------------|------------|--------------------------------------|---|---|
| Part II. Othar significant conditions | contributing to death but not res | sulting in the underly | ying caus | a givan in Part I. | 23b. Did tobacco use c 1 ☐ Yes 2 ☐ No | ontribute to the cause of death? |
| | | | | | 24a. Was an autopsy performed? INSPECTION 1 □ Yas 2 | 24b. Wera autopsy findings available prior to complation of ceusa of death? 1 □ Yas 2 □ No |
| 25. Was cese refarrad to medicel | | | | 26. Pleca of De | eath (Check only one) | |
| examinar? Yes 2 No | Hospitel: 1 ☐ Inpatiant 2 ☐ | ER/Outpatient 3 | □ DOA | Other: 4 Nursing | Homa 5 Residance 6 □Ot | har (Specify) |
| 27. Manner of Deeth XX Natural 5 ☐ Pending 2 ☐ Accidant Investigation | 28a. Data of injury (Month, Day Year) | 28b. Time of Injury | | Injury at Work? 1 □ Yas 2 □ No | 28d. Dascribe how injury occu | rred |
| 3 Sulcida 6 Could not be determined | | ome, farm, streat, f | actory, of | fice | 28f. Location (Straat and Num City or Town, Stete) | ber or Rural Routa Number, |

29a. Certifie (Check only one)

Certifying Phyaician: To the bast of my knowledge, death occurred at the time, dete and piece, and due to the causa(s) and mannar as stated. 2XXXMadical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end piece, and due to the ceuse(s) and manner stated.

29b. Signatura and titla of certifier

29c. Licansa number 29d. Data signad (Month, Day, Year)

O.C.M.E AUG. 23, 1997

30. Nema and address of person who completed ceuse of death (item 23e) (Type, Print)

Donald G. Wright M.D.

31. Deta filed (Month, Day, Year)

SEP 0 8 1997

111 Penn Street, Baltimore, Maryland 21201

State Registra

Medicai

. 32. Pegistrar's Signature

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month September 4b. City, Town, or Location of Deeth 5:30 Am 1997 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) tayette Street 7. Age (In yrs. last birthday) if Under 1 Yeer 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 10 M 2□ F Months Days Ma 216-05-467 Yrs. Usual Residence of Deceden 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 No NA 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2230 Street tayette 41223 11. Marital Status 12. Was Decedent Ever In U.S. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□ Yes 200 No Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Rusiness/Industry Security Social Elementary/Secondary (0-12) Coilege (1-4or 5+) Chief th grade 12 Administration 4yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Saunders Sturgess Енна 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Bertha 20b. Place of Disposition (Name of Cemetery, crematory or other place) treet tayette Ba Ho, red 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Uwings 21. Signature of Funeral Service Licensee Name and Address of Facility Balto, rel Valast 0 23a. Part1. Enter the disease, or complications that caused lhe death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsel and Deeth Immediate Cause (Finel RESpiratory diseese or condition resulting in death) 1043 EmphysEmn Due to (or es e consequenca of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Itypeatension 24b. Were eutopsy findings evallable prior to completion of cause of death? 24e. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No

Physician /Medical Examiner

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certificate has

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics

page 2 should be

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Completed

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10

Certification:

Medical

P.O. Box 68760.

Records,

Division of Vital

Physician

/Medical

Examiner

10a. State

Md

Director

Funeral

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Completed

Be

Funeral

Director

show

itam 27 is merked other than "natural", or items 23a or 28a-f show other traumetic event, tra Medical Examiner must be notified at

pemit. Pages 1 and 2 should be filed within i Department of Health and Mental Hygiene. Important: if itam 27 is merked other than "n any Injury or other traumatic event

death with the Maryland

72 hours after

Baltimore, Maryland 21215-0020

Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Physician/Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

26. Place of Death (Check only one)

MD 21201

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death

28a. Date of Injury (Month, Day Year) 5 Pending investigation

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Natural

2 Accident

4 Homicide

3 Suicide

Certifying Physician: To the best of my knowledge, death occurred at the time, dete end pleca, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

295

29b. Signature and title of certifier mo mb

6 Could not be determined

D32273

PALA ST

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID

22. Rightstrans Signature 31. Date filed (Month, Day, Year) SEP 0 9 1997

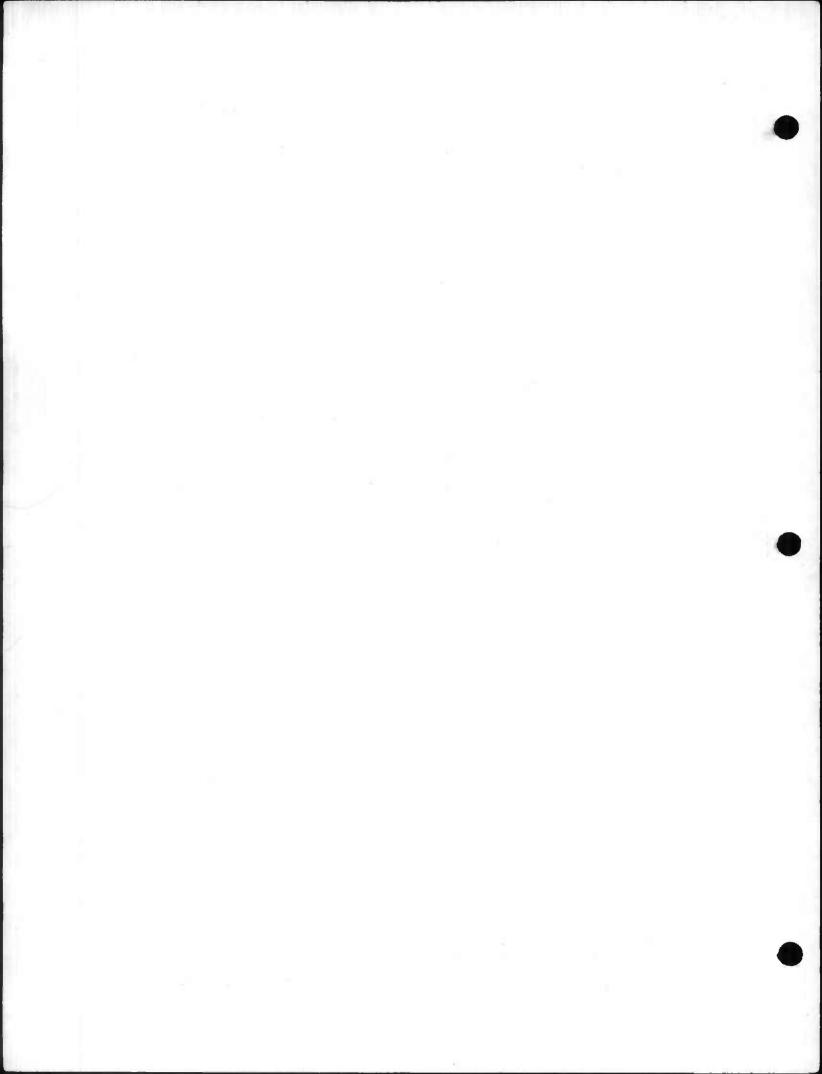
State Registrar

m.

A compa

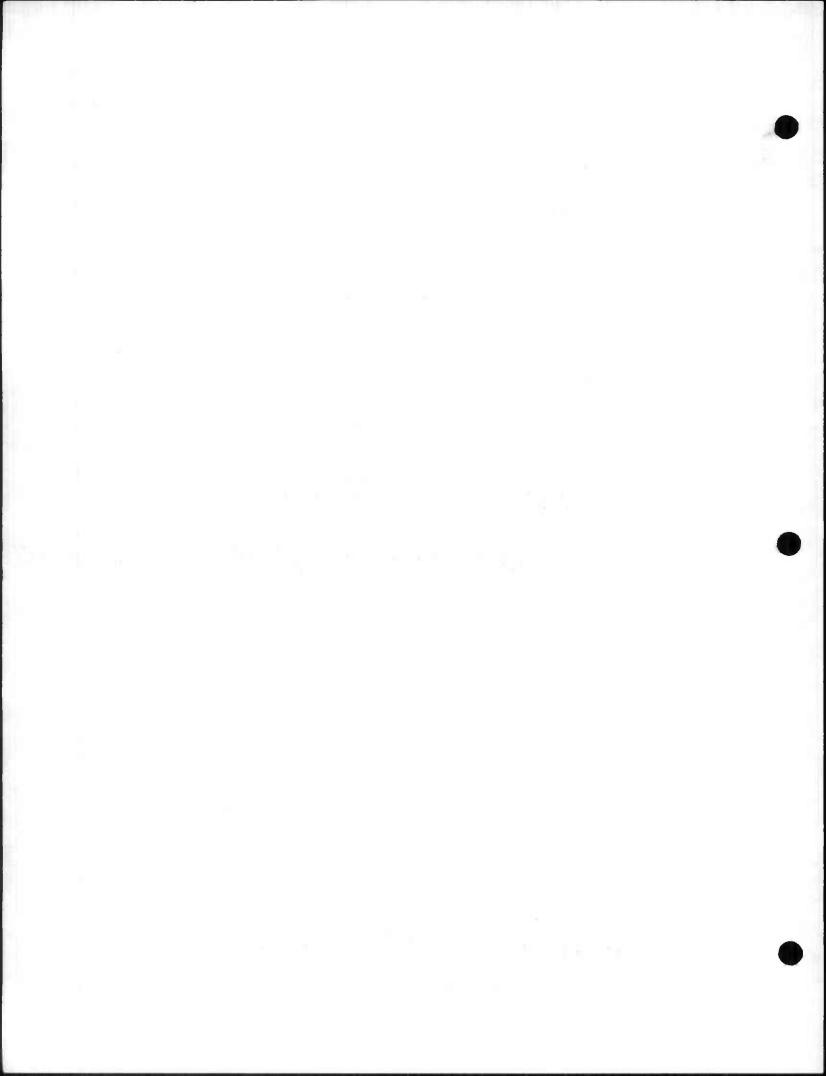
| MARI | E S | UE | DAVIS Items: 23 par | t I,27,29a-f | | | | Health and I Death | | Reg. No. | | 27200 |
|--|--|---------------------|--|---|---|---------------------------|--------------------------|---|-----------------------------------|-----------------------------------|--|---|
| Ph | ıysici | an | Decedent's Neme (First, Middle, I | , | | | | | 2. Date of D Month | Day | Yeer | 3. Time of Deeth |
| // | Medic | al | MARIE | | VIS | | | 4b. City, Town, or I | | | 1997 | 10:45 AM |
| E) | kamin | er | 4a. Facility Neme (If not institution, g 232 EAST HIGH S | | ar) | | | | Location of Dee | | | |
| Form | a mal | | | | Age (In yrs. lest b | irthdev) If Un | der 1 Year | ELKTON If Under 24 Hrs. | 8. Dete of B | CECII | | lece (Stete or Foreign |
| | neral Ictor | | 292-56-5685 | 1□ M 2□ F | 41 | Yrs. Mont | ns Deys | Hours Min. | OCT 21 | 1955 | Coun | iana |
| p , | 20 | | Usuel Residence of Decedent | | 10.00 | | | | | | | |
| e Marylar | titled at | ctor | MD 10b. County Cec | il | | wn or Location Cton | | | | | 10 | od. Inside City Limits 1 ☐ Yes 2 No |
| ith the | 2 P | Dire | 10e. Street end Number | | | 10f. | Zip Code | | | 10g. Citizen of | Whet Coun | try? |
| eth w | Matt | rai | 232 East High | Street | | | 219: | | | US. | | |
| 72 hours after deeth with the Maryland natural; or items 23a or 28a-1 show | the Medical Examiner must be notified at | by Funeral Director | 11. Marital Status 1 □ Never Married 2 □ Merried \$ □ Widowed 4 □ Divorcad | 12. Wes Decede Armed Force 1 XYes 2[If Yes, Give Year or Date: | s? □No 1975 | | | dispanto Origin? (S en, Mexican, Puert Specify: | pecify Yes or N o Rican, etc.) | Special | ce - America ck, White, e by: Wh | |
| nd 2 should be filed within 72 hours af lith and Mental Hygiene. | Sal | ted | 15. Decedent's | Education | 16 | Decedant's U | sual Occup | petion | | 16b, Kind of E | lusiness/Ind | lustry |
| thin 7 | Med | Completed | (Specify only highest of Elementery/Secondary (0-12) | college (1-4c | or 5+) | (Give kind of lifa. DO NO | work done Tusa retire | during most of wor d) | rking | | | |
| e filed within Il Hygiene. other than | 4 | Con | 8 | | | Vursin | g As | sistant | | VA H | ospit | al |
| tal H | | Be | 17. Father's Neme (First, Middle, La | * | | | | 18. Mother's Nan | | | | |
| should be nd Mental marked o | | To | Jessie L | | | | | | | e McQu | | |
| d 2 sho h and ls me | | | 19a. Informent's Name/Ralationship Thomas W. Grable | | | | | end Number or Au St. Hav | | | | |
| Peges 1 and 2 ment of Health a | ther | - | 20a. Mathod of Disposition | , 011 110000 | | of Disposition (| | De. Hav | Deta | 20c. Location | | |
| vermit. Peges 1 ar Depertment of Hear | o o | | 1 ☐ Burial 2 X Cremetion 3 | | ceme! | ery, cremetory | or other ple | | | | - 1 | |
| it. P | njun, | - | 4 Donation 5 Other (Spec | city) | metr | | | Inc. 09 | | Baltimo | | עו |
| permit. Peges Depentment of Important: If It | any lr | | Dawn F. McDo 23e. Pert1. Entar the disease, or co shock, or heart feilure. List on | naid Wo | nald | 299 | Frede | Society rick Rd. | Baltim | ore, MD | nc. 21228 | |
| death certificate be executed attending physician and | is the burial-transit | /Medical Examiner | disease or condition resulting in deeth) Sequentlelly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted evants resulting in deeth) Lest | a. ALCOHOL b | | consequance | of): | | | | | |
| eath cert | for u | cian | | | | | | | | | i | |
| t the c | letached | Physician/M | Pert II. Other significant conditions | contributing to deeth | but not rasulting | in the undertyin | g cause giv | ven in Pert i. | | tobacco use co | 3 Prob | the cause of death ably 4 Unknow |
| requires been sign | should | Completed by | | | | | | | | s an autopsy formed? | ave | ore eutopsy tindings bilable prior to npletion of cause daeth? |
| The law | page | E | | | | | | | 12 | Yes 2□No | 1 2 | Yes 2 No |
| | rector, | Bec | 25. Wes case referred to medical exeminer? | | | | | 26. Piece of Dee | th (Check only | one) | 1 | |
| Physician: this certific | ਰ | To | 1⊠ Yes 2□ No | Hospital: 1 ☐ Inpa | tient 2 ER/C | utpatient 3□ | DOA Oth | nar: 4□ Nursing H | ome 5 Re | sidence 6 🗆 Oti | ner (Specify |) |
| | funeral | .i.o | 27. Mannar of Death 1 □ Neturel 5 □ Pending | 28a. Date of tr (Month, L | jury 28b. Dey Year) | Time of Injury | 28c. Injui Wor | y et rk? | 28d. Describe | how injury occu | rred | |
| Attending r death. actor: Afte | the f | Certification: | 2 ☐ Accident Investigati 3 ☐ Suicide 6 ☐ Could not | he | · | nown M | 1 | Yes 200 No | Unknown | | | |
| or Attendate deat Director: | in by | artif | 4 ☐ Homicide detarmine | building, | njury - At home, f etc. <i>(Specify)</i> | erm, straet, fac | tory, office | | | (Street end Num own, Stete)232 | East H | ligh St. |
| Hospital 24 hours a Funeral C | completely filled in by the | | 29a. Cartifier 1□ CertifyIng F | Found at | | o dooth course | ad at the ti- | wa data and alasa | | ton, Md. | | atod |
| Hos 24 ho | etely | edicai | | hyaicien: To the bes aminar: On the basis and menner: | of exeminetion e | | | | | | | |
| To the within 2 | ldmo | Me | 29b. Signeture and title of certifier | and mornor | Jiaiou. | _ | 29c. Licens | e number | | 29d. Date signe | ed (Month, L | Day, Yeer) |
| - > - | ٥ | | DT/ O | 11-11. | | | o.c. | M.E. | | SEPTEME | BER 02 | .1997 |
| r | 2 | - | 30. Name end eddress of person who | complated causa of | death (Itam 23a) | (Type: Print) | 0.0. | | | | | ,, 2, 3, 1 |
| | 2 | | THEWORE M.K | S | | | et, B | altimore | , Maryl | and 2120 |)1 | |
| | Stat | te | 31. Date filed (Month, Day, Year) | 32 Regis | rer's Signeture | | | | | | | |
| Re | gistra | | SEP 0 9 1997 | guing De | widson-Ran | dell | | | | | | |

Registrar DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 97 27286

| | | | | | | Certificate of Death | | Reg. No. | • | _ / _ 0 0 |
|----------------|--|------------------|---|--|----------------------|--|------------------------------------|-------------------------------------|---------------------------|---|
| | Physic | lan | Decedent's Neme (First, Middle, La | | | | 2. Deta of De Month | | Yeer | 3. Tima of Deeth |
| | /Medi | | Kenr | | bso | | SEPT. | 5, Dey 199 | | 7:30pm |
| 1 | Exami | ner | 4e. Facility Neme (If not institution, git 5231 Talbot's | | | 4b. City, Town, or L Ellicott | City | Howa | | |
| | Funeral Director | | | Sax 7. Age (In yrs. 73 | | hday) If Under 1 Yeer If Under 24 Hrs. Months Days Hours Min. | (Month, De | th by, <i>Year)</i> 19, 1924 | 9. Birthp Cour Maj | olece (Stete or Foreign ory) ryland |
| | Maryland H show | tor | 10e. Stata 10b. County Howard | | | or Location Cott City | | | t | 1 Od. inside City Limits |
| | h with the | Funeral Director | 10e. Street end Number 5231 Talbot's | Landing | | 10f. Zip Code 21043 | | 10g. Citizen of V USA | Vhat Cour | ntry? |
| 020 | n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show rotical Examiner must be notified at | þ | 11. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced | 12. Wes Decedent Ever in U Armed Forcas? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes: WW | ,s. II | 13. Wes Decedent of Hispanic Origin? (Spif Yas, specify Cuban, Mexican, Puerto | ecify Yas or No Rican, etc.) | 14. Red Blac Specify | ck, White, | can Indien, etc. |
| 5-0 | 72 ho | ted | t5. Decedent's E | ducation | 16e. | Decedent's Usuel Occupation | rina | 16b. Kind of Bi | usinass/in | dustry |
| 21215-0020 | C | Completed | Elementery/Secondary (0-12) | Coilege (1-4or 5+) | 1 | (Give kind of work done during most of work life. DO NOT use retired) ales Representati | | Storag Undergr | | |
| Maryland | should be filed with nd Mantal Hygiana. I marked other than umatic event, the M | To Be | 17. Fether's Neme (First, Middle, Last Lawrence |) William Dobs | son | 18. Mother's Nam Ethel | e (First, Middle, Emma | | ie) | |
| Jar | and and and | | 19a. informent's Neme/Reletionship | | 19b. | Meiling Address (Street end Number or Rus | al Route Numb | er, City or Town, | Stete, Zip | Code) |
| altimore, A | of Haali of Haali litem 2 r other | | Charlotte A. Dobs 20e. Method of Disposition 1 Buriel 2 Cremetion 3 E 4 Donetion 5 Other (Specia | Removel from Stete | Place of cemetery | 31 Talbot's Landing Disposition (Neme of v, cremetory or other plece) Forest MD VA Cemetery 9/ | Dete | t City, 20c Location - Owings | City or To | own, State |
| Baltir | permit. Pag Department Important: If any Injury o | | 21. Signeture of Foneral Sarvice Lice | ** | | MacNabb Funeral Horasol Frederick Rd. | me, P.A | | | |
| | | | Dawh F. McDon 23e. Pert1. Enter the disease, or com | a1d pplications thet caused the deel | h. Do n | ot anter the mode of dying, such es cardiac | | | 1220 | Approximate |
| u | Physician | | snock, or neer feilure. List only | one ceuse on eech line. | , | | | | - | Interval Between Onset and Death |
| 1 | /Medical Examiner | | immediete Ceuse (Final disease or condition resulting in deeth) | · Strute | leye | rodal Sofare | tion | - | | Timedial |
| L | ΔШ, | Jer l | Local Control | Due to (| ghro | onsequence of): | | | | |
| , · | cata be axecuted physician and s tha burial-transit | Examiner | Sequentially list conditions, if eny, leading to immediate cause. Enter Undertying Cause (Disease or Injury that initial departs) | b. — Due to (d | or es e co | onsequenca of): | | | | |
| x 68760, | E 0 6 | Medical | Cause (Disease or injury that initiated events resulting in deeth) Lest | Due to (c | r es e co | onsequence of); | | | | |
| O. Box | tha death ce y tha attandii ached for usa | Physician/I | Pert II. Other significant conditions of | | ulting in | the underlying cause given in Pert I. | 23b. Did | tobacco use co | ntribute to | o the cause of deeth? |
| σ. | that ed b | by Ph | | | | | 10 | Yes 20 No | 3 Prol | bably 4 ☐ Unknown |
| Vital Records, | v requin | Completed b | | | | | | en eutopsy omed? | av. | ara autopsy findings relieble prior to empletion of causa death? |
| Ä | a - 0 | E O | | | | | 10 | Yes 2 No | 1[| ☐Yes 2☐ No |
| /ita | | Be (| 25. Wes case referred to medical exeminer? | | | 26. Plece of Deel | h (Check only o | one) | | |
| of | Physician: this cartific tral director, | 2 | 1 Yas 2 No | · · · · · · · · · · · · · · · · · · · | ER/Out | | | dance 6 Oth | | ý) |
| ono | Aftar funar | tion | 27. Menner of Deeth 1 Neturel 5 Pending 2 Accident investigatio | 28e. Dete of injury (Month, Dey Year) | 28b. Ti | me of 28c. injury et 28c/y inj | 28d. Describe | how injury occur | red | |
| Division | To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune | Certification: | 2 Accident investigatio 3 Sulcide 6 Could not be determined | e one Place of Injury. At h | ome, fen | | 28f. Location (: City or To | Street end Numb wn, State) | er or Rure | el Route Number, |
| | n 24 hours on Funeral blataly filled | edical C | 29a. Certifier (Check only one) 1 Certifying Pt 2 Medical Example 1 | nysician: To the best of my kno niner: On the basis of examine and menner steted | wledge, tion end | deeth occurred et the time, date end plece, /or investigation, in my opinion, death occur | end due to the red et the time, | ceuse(s) end ma date end place, | inner es si end due to | teted. o the ceuse(s) |
| | To the vithin 2 To the complex | M | 29b. Signeture and title of equilier | a-Allin | El | D 29c. License number 8649 | 7 | 29d. Days signe | g Month. | Day, Year) |
| | 18 | | 30. Name end eddress of person who MICHAEL A. E. | LUS MD 31 | 149 | WILKENS Avert | 1305 | Rain | Na | 21279 |
| | Sta Registr | | 31. Dete filed (Month, Day, Year) SEP 0 9 199 | 32. Redistrer's Signa Tuna Day | dien- | Pandelle | | Of town | | -1, |



| | | | | Please | Type or Pr State of N | | d / Dep | artme | nt of I | . Assure A lealth and I Death | Mental Hyg | _ | ible. 97 | 27287 | | |
|------------|---|-------------|--|-----------------------------|---|----------------------|-----------------------------|------------------|--------------------------------|---|---|--|------------------------|--|--|--|
| П | Dhuala | 100 | 1. Decedent's Name (Firs | | | | | | | | 2. Date of Dea Month | _ | Venr | 3. Time of Death | | |
| | Physic /Medi | | Ann Cha | mbers | Dill | | | | | | Sept. | 2, 19 | 97 | 6:50 pM | | |
| þ | Exami | | 4a. Facility Name (If not in Keswick | | | | | | | 4b. City, Town, or Baltim | | 4c. County | of Death | TEST | | |
| | Funeral Director | Г | 5. Social Sacurity Number 219-28-93 | 52 | Sex 7. A I□M 2X F | nge (In yrs. 82 | last birthday) Yrs. | If Und Months | ar 1 Year Days | | 8. Date of Birth (Month, Day 07-26- | 1915 | 9. Birth Cou Mar | olace (State or Foreign ontry) | | |
| | 2 . | | Usual Residence of Dace 10a. State 10b. | dent County | - | 10c City | y, Town or Lo | cation | | | | | | | | |
| | with the Marylan a or 28a-f show be notified at | tor | MD | NA | | | altim | | | | | 8. Date of Birth (Month, Cay, Year) (Month, Year) (Month | | | | |
| | 0r 28 | Director | 10a. Straat and Number | | | | | 10f. Z | ip Code | | 1 | 0g. Citizen of | What Cou | ntry? | | |
| | in with | | | | | | | | | US | A | | | | | |
| 020 | hours after death wit ursf, or items 23a o al Examiner, must be | by Funeral | 11. Marital Status Warled 2 3 Widowed 4 D | _ | 12. Was Deceder Armed Forces 1 ☐ Yes 2/C If Yes, Give Yaar or Dates | ? X No | | | edent of I ecify Cub | Hispanic Origin? (S an, Mexican, Puert Specify: | pecify Yes or No- o Rican, etc.) | Bla | ck, White, | etc. | | |
| 20 | 72 ho | te B | 15. D | ecedent's E | ducation | | 16a. Dece | dent's Us | ual Occu | pation | 4.5 | 16b. Kind of B | usiness/in | dustry | | |
| 21215-0020 | within than the Me | Completed | Elemantary/Secondary | | completed) College (1-40 | 5+) | | rse | ork done us <i>e retire</i> | during most of world) | King | Nu | rsin | ıa | | |
| p | Hygi other ent, s | Be C | 17. Father's Nama (First, | Middle, Last, |) | | | | - | 18. Mother's Nar | Name (First, Middle, Maiden Sumama) | | | | | |
| lar | herta keed keed | To B | Lewis Al | an D |)ill | | | | | Mar | | | | | | |
| Maryland | d 2 shouth and M | | 19a. Informant's Name/Ri Edgar H. | | | Rep. | | | | | | - | | | | |
| Baltimore, | Pages 1 ar | | 20a. Method of Disposition 1 Burial 200 Para 4 Donation 5 0 | nation 3 | | 0 | Place of Disponentery, crea | matory or | other pla | | | | | | | |
| Balti | permit. Departm Importar any inju | | 21 Signature of Funeral S | | | h | - T | Name a | and Addra | ass of Facility | ins & S | Sons | | 21212 | | |
| | Physician | | 23a Furt Enter the dise shock, or heart failur | ase, or com e. List only | plications that cause ona causa on each | d the death line. | h. Do not and | | | | | | 1 | Approximata Interval Between Onset and Death | | |
| | /Medical Examiner | | Immediate Crusa (Final disease or condition resulting in death) | | . Der | Jue to (o | TTOY | Quence of |): | | | | 1 | 7 days | | |
| - | uted Insit | Examiner | | | b. Bro | un | Segi | ria | rd | Syno | trome | 0 | | years | | |
| ó | axecuted an and nal-transit | Exa | Sequentially list condition if any, leading to immedia cause. Entar Underlying | s, te | 5:01 | Di 919 (0 | r as a consec | ≥ M(⊃ | | | | | | 11001/6 | | |
| 9289 | ysicia ye bu | cai | Cause (Disease or Injury that Initiated events | ~ | c. UP | Due to (or | r as a consac | | |) | | | | years | | |
| Box 68 | aath certificate be ax attending physician for use as the buna | ician/Medi | resulting In death) Last | L | o org | anic | d | eme | ent | ia | | | | 2 years | | |
| | the atter | sicia | Part II. Other significant of | onditions o | ontributing to death | but not rasu | ulting in the u | nderlying | causa gi | van in Part I. | 23b. Did to | obacco use co | ntribute t | o the cause of death? | | |
| S, P.O | that the | by Physi | | | | | | | | | 1 □ Y | 20 No | 3 ☐ Pro | bably 4 Unknown | | |
| Records | law requires t las been signe 2 2 should be | Completed b | | | | | | | | | 24a. Was a perform | | av cc | 'ara autopsy findings vallable prior to impletion of ceusa daath? | | |
| | The la | Con | | | | | | | | | 1 □ Y | as 2 No | 1 | □Yas 2□ No | | |
| of Vital | Physician: The this certificata ral director, pag | Be | 25. Was casa referred to examinar? | medical | Hoonital: | | | | | | th (Check only or | 10) | | | | |
| of | 5 5 | 2 | 1 Yas No | | Hospital: 1 ☐ Inpat | | ER/Outpatier | | JUA | | lome 5 Reside | | | fy) | | |
| ion | nding Ph ath. r: After th | ation: | 27. Manner of Death 1 Natural 5 2 Accident | Pending Investigation | 28a. Date of In (Month, D | | 28b. Tima o Injury | f M: | 28c. Inju Wo 1 □ | ryat rk? !Yes 2 □ No | 28d. Describe he | ow injury occui | Tea. | | | |

Division of Vital Records, P.O. Box 68760, Medicai Certification:

To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this complataly filled in by the funeral of

3 Suicide 4 Homicide 29a. Certifiar (Check only

Certifying Physician: To the bast of my knowladge, daath occurred at the time, date and place, and dua to the causa(s) and mannar as stated.

[2] Medical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and mannar stated.

5 Pending Investigation 6 Could not be datarminad

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of o

29c. Licansa numbar

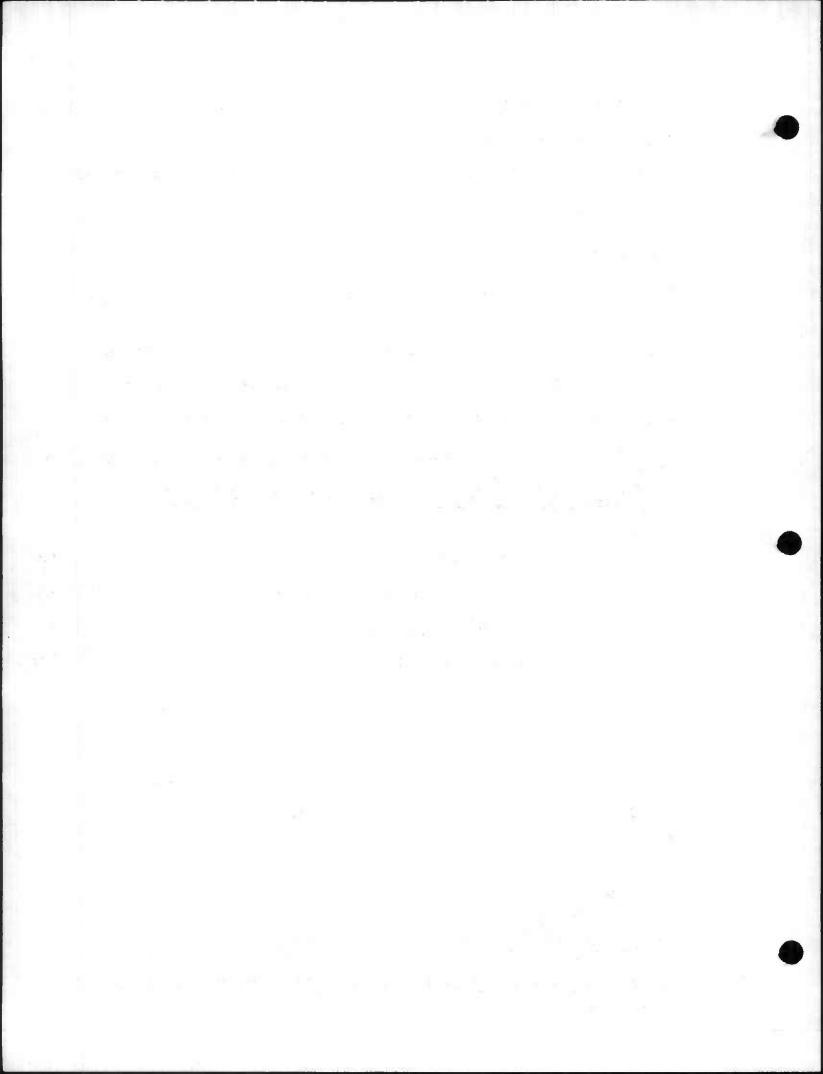
29d. Data signed (Month, Day, Year)

30. Nama and addrass of person who completed causa of daath (Itam 23a) (Type, Print) 3901

JOSEPH Zeloley 31. Data filed (Month, Day, Year) SEP 0 9 1997

332. Ragistrar's Signature

State Registrar

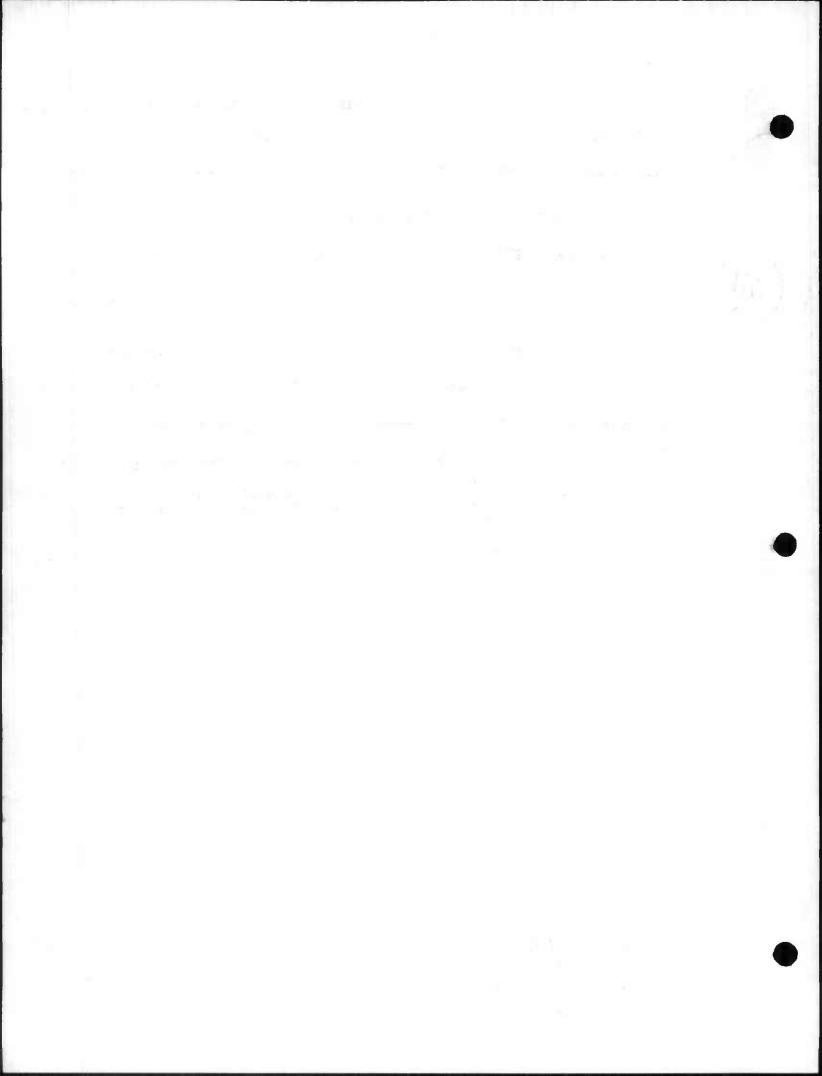


State of Maryland / Department of Health and Mental Hygiene 97 Item19b 9-9-97 FilmG751 W.H.Per F/H Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** SEPT.2, 1997 OIAM ESTHER DAVIS /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MANOR CARE SILVER SPRING MONTGOMERY 5 Social Security Number If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) FEB.10, 1911 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2√X Days 86 Yrs Director NEW YORK 108-20-9044 Usual Residence of Decedent 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits MONIGOMERY 1√Xes 2□No Director SILVER SPRING 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? à 11124 OAK LEAF DRIVE 20901 USA Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black White etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ Xo If Yes, Give Year or Dates: 1 ☐ Yes 2√2No Completed By Specify: 3√Widowed 4 Divorced WHITE Baltimore, Maryland 21215-0 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 5+ the h **TEACHER EDUCATION** Alth end Mental Har 7 fe ment 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be BARUCH ZWANGER YETTA KRUPKA 2 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) permit. Pages 1 end 2 Department of Health e Important: if item 27 is any injury or other tra JANET DAVIS (DAUGHTER) 11125 OAK LEAF DR: SILVER SPRING, MD 20901 20b. Piaca of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH EL MEMORIAL PARK 9-4-1997 RANDALLSTOWN, MD of Funeral Service 22. Name end Address of Facility SOL LEVINSON & BROS, INC. 8900 REISTERSTOWN RD PIKESVILLE, MD 21208 disease, or complications that liure. List only one ceuse on **Physician** /Medical Immediete Ceuse (Final disease or condition resulting In death) Days neumonia Examine Due to (or as a consequence of): Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting In death) Last and Due to (or es a consequença of): Box 68760 Physician/Medical the Due to (or as e consequenca of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown igned l Division of Vital Records, py 24a. Was en eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of deeth? Completed page 2 1 🗆 Yes cartificate 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours ettar death. Funeral Director: After this carific Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No uneral 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide To the Hospital o within 24 hours eff To the Funeral Di completaly filled in 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and placa, and due to the cause(s) and manner as stated. Medicai 29a. Certifier 2 Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mory 30. Name and address of person v no completed cause of death (Item 23e) (Type, Print) Moy MD 14333 Laurel Bowie Rd #307 Laurel MD 20708 Jenny

State Registrar

31. Date filed (Month, Day, Year)

SEP 0 9 1997



State of Maryland / Department of Health and Mental Hygiene

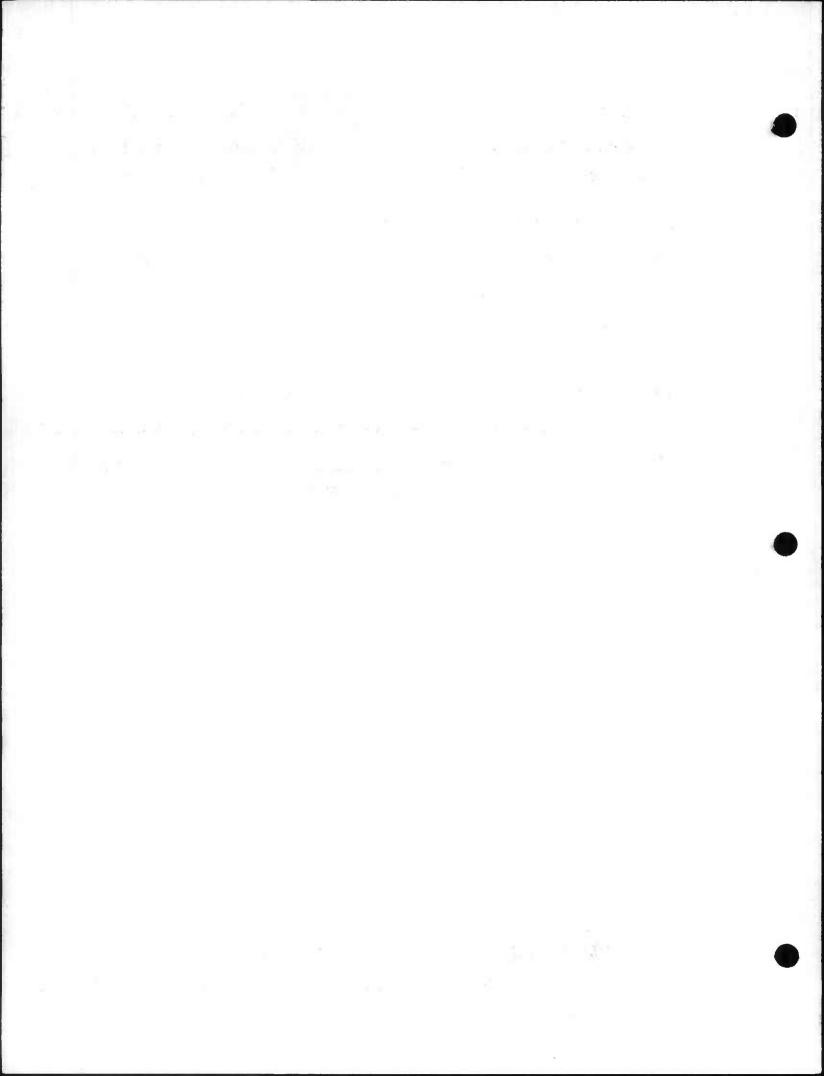
Items7,8,10b,10c,10e,10f,19a,19b 9-9-97 FilmG751 W.H. Per Certificate of Death F/H 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1997 MATILDA DARROUGH SEPT 7:12 PM /Medical 4a. Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RUXTON MANOR CARE RUXTON BALTIMORE 5. Social Security Number If Under 1 Year if Under 24 Hrs. 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) 8. Dete of Birth 1900 (Month, Dey, Year) **Funeral** Days Hours 1 ☐ M 2 🖾 F Yrs Director 96 215-01-5612 RUSSIA NOV.15, 1904 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits N/A Baltimore BALTIMORE MD RUXTON 1KXes 2□No 10e. Street and Number 10f. Zip Code 3628 Elkader Road 21218 10g. Citizen of Whet Country? ä 21204 7001 N. CHARLES STREET IISA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Rece - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: WHITE þ 3√2 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education 22 (Specify only highest grade completed) filed within Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) 朝 12 BUYER RETAIL 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Meiden Surneme) Be Pages 1 and 2 should be and Mental marked **JOSEPH** ROSENBERG LENA KUGEL 2 19a. Informant's Name/Ralationship (Type, Print)

MRS. BEVERLY BERESON (COUSIN) 19b Mailing Address (Street and Numbar or Rural Route Number, City or Town, Stete, Zip Coda) # 3919 KEYSER RD. of Health I Item 27 Is BALTIMORE, MD 20b. Place of Disposition (Neme of cametery, cremetory or other pleca) 20c. Location - City or Town, State 20a. Method of Disposition B Important: If II any injury or 1 Burial 2 Cremation 3 Removal from State 9-4-1997 BALTIMORE, MD MOther (Specify) ENTOMBMENT LORRAINE PARK 21. Signature of Runeral Service License 22. Name and Address of Facility
SOL LEVINSON & BROS., INC. 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Entar Undarlying Causa (Disease or Injury that initiated events rasulting in death) Last physician s the burial P.O. Box 68760, Physician/Medicai attending 0 signed by the aild be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably ≰© Unknown Division of Vital Records, ρ should b 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy ate has 1 Yes 20 No 1 ☐ Yes 2 12 No certificate the Hospital or Attending Physician: hin 24 hours after death. director. 25. Was case referred to medical Be 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No. 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Data of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: After Natural Injury 5 Pending 1 Yes Investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) Placa of Injury - At home, farm, streat, factory, office building, etc. (Specify) filled in by 4 Homicide à within 24 hours a
To the Funeral D
completely filled edical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ■ Medical Examiner; On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of 29d. Date signed (Month, Dey, Yeer) c. License numbe 30. Name and address ed cause of death (Item 23a) (Type, Print) 92. Registrar's Signature State Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

| | | | | | , | C | ertificate | e of | Death | | Reg. No | · 9 | 1 6 | 116 | 290 |
|------------|--|----------------|---|---|---|------------------|--|------------|--|--------------------------------------|---------|-------------|-----------------------------|----------------------|------------------|
| | Dhusia | | 1. Decedent's Name (First, Middle, La | ast) | | | | | | 2. Date of De Month | ath | ay | Year | 3. Time | of Death |
| | Physici /Medi | | SARAH E. DORN | | | | | | | Sept | 2 | 2,10 | | 2:0 | M.AG |
| <u>خ</u> | Examir | er | 4a. Facility Name (If not institution, given | | • | | | | 4b. City, Town, or | Location of Deat | h 40 | c. County | of Death | | |
| _ | | | WILLIAMSPORT NUR 5. Social Security Number 6.5 | | | and falletten | av) If Under | 1 Voor | WILLIAM: | | 1 | WASH | INGTO | N | |
| | Funeral Director | | | 1□M 287 € | ge (In yrs. la | Yrs | Months | Days | Hours Min. | | |) | 9. Birthpi Count | ece (Sta | te or Foreign |
| | Manual Ma | | 10a. Stete 10b. County | | 10c. City | Town o | Location | | | | | | 10 | d. Inside | City Limits |
| | a-t st | otor | MD WASHIN | IGTON | W | LLI | AMSPORT | | | | | | | 1 <u>X</u> 1 Y | es 2 No |
| 3 | 100 | Director | 10e. Street and Number | | | | 10f. Zip | Code | | | 10g. C | itizen of V | Vhat Count | iry? | |
| 1 | MA | Tal. | 154 N. ARTIZAN S | Т. | | | | 795 | | | | .S.A. | • | | |
| 020 | | by Fune | 11. Meritai Stetus 12 Never Married 2 Married 3 Widowed 4 Divorced | 12. Wes Deceden Armed Forces 1 Tyes 2X If Yes, Give Year or Dates | ?] No | 3. | 3. Was Deceded If Yes, special 1 Yes 2 | | Hispanic Origin? (Sen, Mexican, Puer Specify: | specify Yes or No to Rican, etc.) |)· | | e - America ok, White, e | etc. | • |
| 5-0 | 72 To | eted | 15. Decedent's E (Specify only highest gro | ducation ade completed) | | 16a. De | cadent's Usual | l Occup | pation during most of wo | rkina | 16b. I | Kind of Bu | siness/Ind | | |
| 21215-00 | Pan Pan | Completed | Elementary/Secondary (0-12) | College (1-4or | 5+) | Tit | e. DO NOT us | e retire | d) | iking | | | | | |
| | her th | S | 1 2 17. Father's Name (First, Middle, Last | 5 | | TE | ACHER_ | | 18. Mother's Na | ma /Firet Middle | | DUCAI | | | |
| an | d be d be d be d be d be d be d be d be | o Be | | '/ | | | | | | - M. Howard | | II Sumam | (6) | | |
| Maryland | shoul nd Me mark mark | 70 | SAMUEL B. DORN 19a. Informant's Name/Relationship | (Type, Pnint) | | 19b. M | ailing Address | (Street | JESSII and Number or Re | E_LOVETT | , | or Town. | State. Zip | Code) | |
| | anth a 27 is ar tras | | LOUISE C. PALMER/ | | ER | | | | OUN CT. | | | | | | 21742 |
| ore | of Hall of Hall litem 2 r other | | 20a. Method of Disposition 1 ☑ Buria 2 ☐ Cremation 3 ☐ | | 20b. Pi | ace of Di | sposition (Namerematory or ot | e of | 1 | Dete | 20c. L | ocation - | City or To | wn, Stete | |
| Ĕ | sit. Page artment o ortant: If injury or | | 4 Donation 5 □Other (Special | THemoval from Stati | | EN E | HILL CE | METI | ERY | 9/4/97 | MAI | RTINS | BURG | . WV | |
| Baltimore, | permit. Depart Import any inj once. | | 21. Signature of Funeral Service Lice | nsee | | | | FUN | ess of Facility ERAL HOME | Е РО ВОХ | 82 | 1 | | | |
| | | | 23a. Part1. Enter the disease, or com shock, or heart failure. List only | plications that cause | ed the deeth | Do not | enter the mode | of dyl | NG ST., 1 ng, such as cardia | c or respiratory a | urrest, | • WV | 2540 | Approxir Interval | nate |
| ď | Physician | | anoon, or near rande. List only | | | | | | | | | | 1 | Onset e | nd Death |
| 74 | /Medicai Examiner | | Immediate Cause (Final disease or condition | a Bacte | riol | Proe | curoni | 6 6 | and Su | epticen | , sin | 4 | 10 | WE | 3EK |
| | LAUTITIO | 7 | resulting in death) | | | | sequenca of): | | | 1 | | | i | | |
| | ned ned | min | • | b | | | 1 | | | | | | | | |
| Ć | tificata be executed ig physician and as the bunal-transit | Examiner | Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that Initiated events | | Due to (or | as a con | sequenca of): | | | | | | į | | |
| 68760, | ysicia | edicai | Cause (Disease or injury that Initiated events | C | Due to (or | es e con | sequence of): | | | | | | <u> </u> | | |
| | E 0 6 | Med | resulting in death) Last | | | | | | | | | | | | |
| Box | th certendir | an/ | | d | | | | | | | | | 1 | | |
| 0 | that the death cer ed by the attendir datached for use | Physician/M | Part II. Other eignificant conditions of | contributing to death | but not resu | ting In th | e underlying ca | ause giv | ven in Part I. | 23b. Did | tobacc | o use cor | ntribute to | the cau | ee of death? |
| Δ. | ⇒ ≥ ° | Phy | | | | | | | | 1 🗆 | Yee | 2 No | 3 Prob | ably 4 | Unknown |
| Records, | 8 58 | d by | | | | | | | | 24a. Was | en auto | onev | 24b. We | re auton | sy findings |
| S | O | Completed | | | | | | | | perf | ormed? | Jpay | avs | nilable pri | or to |
| | 62 CA | dwc | | | | | | | | 40 | Vac 1 | MNO | | death? | Vine |
| Vital | delan: The | Be Co | 25. Was case referred to medical | | | | | | 26 Place of De | ath (Check only | | SCHO | 1 | Yes 3 | No No |
| Į V | Physician: this certific ral director, | To B | examiner? | Hospital: | ient 2 🗆 E | R/Outpa | tient 3 DO | A Oil | nor: \ / | dome 5□Res | | 6 □Oth | er (Specify | () | |
| n of | ng Ph ter th meral | | 27. Menner of Death 1 Natural 5 ☐ Pending | 28a. Date of In (Month, D | ury ay Year) | 28b. Tim Inju | e of 28 | Bc. Injui | | 28d. Describe | | | | | |
| Sio | eath. or: Al | catio | 2 Accident investigatio 3 Suicide 6 Could not b | n. | | | М | | Yes 2□No | | | | | | |
| Division | or Att | Certification: | 4 Homicide determined | 28e. Placa of It | njury - At hor etc. <i>(Specify)</i> | ne, farm | street, factory, | , offica | | 28f. Location (City or To | | | er or Aura | Route A | lum <i>ber</i> , |
| | pital ours a eral [| | 29a, Certifier 104 Certifying Pt | hyelcian: To the bes | of my know | ladaa d | anth accurred and | et the tir | me date and place | and due to the | 001100/ | a) and ma | | ntod | |
| | 24 h | edical | (Check only one) 2 Medical Example (Check only one) | miner: On the basis and manner s | of examination | on and/o | r investigation, | in my c | opinion, death occu | rred at the time, | date an | id place, | and due to | the caus | e(s) |
| | To the Hospital or Attending Physicien: The is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page | Me | 29b. Signature and title of gertifier | | | | 29c. | Licens | se number | | 29d. D | ate signe | d (Month, L | Day, Yea | r) |
| | | | TEDAUR | m | | | | D | 3370 | 0 | Sed | tembr | 7 | | 797 |
| | (10) |) | 30. Name and address of person who | completed cause of | death (Item | 23a) (Ty | pe, Print) | 1 | 3310 ok Pt | | - | 1011100 | - C | 1 | 1.3.6 |
| 37 | | | Ted E. Howe | m.D. | 75 | 42 | Over | 10 | ok Pr | . V300 | ms | bor | o,m | 0 8 | 21713 |
| | Sta | | 31. Date filed (Month, Day, Year) | 32. Regis | trar'a Signati | Jre ∽ | | | | | | | | | |
| | Registr | ai | SEP 0 9 199 | gan | L wands | on-R | indelle | | | | | | | | |



| | | | te of Marylar | | tificate of | | | Reg. No. | 1 4 | 1291 |
|---|------------------|--|--|---------------------------------|---|---|---|--------------------------------------|------------------------------|--|
| Physic /Medi | | 1. Decedent's Neme (First, Middle, Lest) | 0 | UC | 070 | 9 | 2. Date of Dec | Dey 25 | Yaar S97 | 3. Time of Deeth |
| Exami | | 4e. Fecility Neme (If not institution, give street e | nd number) | | | 4b. City, Town, | or Location of Death | 4c. County | of Deeth | PM. |
| 12.5 | | 2518 E. Baltimore S | | | | Baltimo | | Balti | | |
| Funeral Director | | 5. Social Security Number 439-07-6462 Usuel Residence of Decedent | 7. Age (In yrs. 78 | lest birthday) Yrs. | If Under 1 Yaar Months Days | | in. (Month, De | h y, Year) 3, 1919 | 9. Birthple Count unkn | ece (Stete or Foreigr ry) OWN |
| land ow | | 10e. Slete 10b. County | 10c. Cit | ty, Town or Loc | cation | · | | | 10 | d. tnside City Limits |
| Marylan -f show | to | Maryland Baltimore | City Ba | ltimore | 2 | | | | | t¶ Yes 2□ No |
| th with the M 23a or 28a-f unt be notified | Funeral Director | 10e. Street end Number 2518 E. Baltimore St | treet | | 10f. Zip Code 21 | 213 | | 10g. Citizen of W | Vhat Count | ry? |
| items items | by Funera | 1 Never Merriad 2 Married 1 If Y | s Decadent Evar in Uned Forces? unkn Yes 2 No es, Give | own If | Ves Decedent of I | dispenic Origin? an, Mexicen, Pu Specify: | (Specify Yes or No- erto Rican, etc.) | | - America k, White, e | tc. |
| 72 hours | | | er or Detes: | | | | | | | |
| d 2 should be filed within 72 hours aff in and Mantal Hygiena. 7 is marked other than "natural", or traumatic event, the Mod sale trans | Completed | | lege (1-4or 5+) | (Giva i lifa. D | ant's Usuel Occup kind of work done OO NOT use retire | pation duning most of w d) | vorking | 16b. Kind of Bu | siness/Ind | ustry |
| e filed withing the Hygiena. other than | | unknown unk | nown | unkn | own | 19 Mother's N | eme (First, Middle, | unknov | | |
| nd 2 should be filed with lith and Mental Hygiena. 27 is marked other than traumatic event, the M | To Be | unknown | | | | unkı | | Meldell Sulfielli | a) | |
| should by ind Menta i marked umatic ev | - | 19e. Informent's Neme/Reletionship (Type, Prin | nt) | 19b. Meilin | g Addrass (Street | end Number or | Rural Route Numbe | er, City or Town. | Steta, Zip (| Code) |
| E = 01 . | | unknown | | | nown | | | | | |
| of Herritan | | 20e. Method of Disposition 1 □ Burlel 2 □ Cramation 3 □ Remove 4 □ Donetlon 5 ☒ Other (Specify) | from Stata C | tece of Dispos | sition (Name of etory or other ple | ce) | Date | 20c. Location - | City or Tov | m, Stete |
| permit. Pag Department Important: I any Injury o | | 21. Signeture of Funeral Service Licensee Rona rd S | ade, Dire | ctor | | atomy Bo | pard, 655 and 21201 | | imore | Street |
| Physician /Medical Examiner bh/sicien and the private paragraph of the | al Examiner | Immediate Ceusa (Finel disease or condition rasulting in death) Sequentially list conditions, if any, leading to Immediata cause. Enter Underlying Ceuse (Disease or Injury that initiated evants | | r es e consequ | uence of): | NE R | OR | (060) | | VEARS. |
| death certificate e attending phys of for use as the | ian/Medicai | resulting to deeth) Lest | Due to (or | r as e consequ | ence of): | | | | | |
| 0 0 % | Physician/M | Pert II. Other significant conditions contributing | | | _ | | | | tribute to t | he cause of death? |
| v requires that the been signed by th should be detache | leted by | CONONANY | AREB | NY | Prso | SASR | 24e. Wes e | | avel | e autopsy findings lable prior to plation of causa |
| ician: The law cartificata has b rector, page 2 s | Completed | AORTIC SI | BNOS | 15 | | | 1 🗆 Y | es 2010 | | Yes 213 No |
| Physician: this cartific ral director, | o Be | 25. Wes case referred to medical exeminer? | | | 3E DOA Oth | | eeth (Check only or | ne) | | |
| 문 등 등 | | TEL TES ZEMO | 1 Inpatiant 2 Dete of Injury | ER/Outpatient 28b. Time of | 3□ DOA 28c. Injur | 4 Li Nursing | Home 5 Rasid | ance 8 Othe | | |
| l or Attending Phy after death. Director: After thi d in by the funeral | Certification: | 1 Delural 5 Pending 2 Accident Investigation 3 Sulcide 6 Could not be | (Month, Day Year) | Injury | M 1□ | k? Yas 2□No | | | | Courte Aliverte es |
| To the Hospital or Attend within 24 hours after deati To the Funeral Director: completely filled in by the | | 4 L. Homicide | Place of Injury - At ho building, atc. (Specify | <i>'</i>) | | | 28f. Location (S City or Tow | n, State) | | |
| To the Hospital within 24 hours a To the Funeral I complately filled | edicai | (Check only 2 Medical Examiner: On | o the best of my know the basis of exeminet manner steted. | medge, daeth Ion end/or Inve | occurred et the tirestigetion, in my o | ne, dete end ple pinion, daath oo | ca, end dua to the courred et the time, d | ause(s) and mer late end plece, a | ner as sta nd due to t | ted. he cause(s) |
| To the | Me | 29b. Signature and title of certifier | | | 29c. Licans | a number | 2 | 9d. Data signed | (Month, D. | ay, Year) |
| ->-0 | | D. F. Na | lami | ~ | 017 | 32 2 | | 11-1 | _ | |
| 17 | | 30. Name and address of person who completed | cause of deeth (Item | 23e) (Type. P | rint) | | 10 | 00, | 27 | 1997 7. Mg. |
| | | A. B. NAZI | EMI. M | 1-67 | CHUR | CH 16 | to519 19 | TL B | 11 | T. M.D. |
| | te | 31. Data filed (Month, Dey, Yeer) | 32 Registrar's Synat | 7.00 | | | | | , | 10 |

ng 2 = 2 A

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacedent's Name (First, Middla, Last) 2. Data of Death **Physician** September 6, 1997 Theresa 10:55 pm /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Meridian Franklin Woods Rossville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Data of Birth 11/18/1899 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** Days 1□ M 2₩ F 213 74 0069 97 Yrs. Maryland Director Usual Residence of Deceden 10a, Stata 10b. County 10c. City, Town or Location # 23a or 28a-f show must be notified at 10d. Insida City Limits 1 ☐ Yes 2√ No Directo Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 360 Savannah Road 21221 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes ≥ 2천 No If Yes, Give Year or Dates: Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - Amarican Indian, Biack, White, etc. 11. Maritai Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 No Specify: Completed by Specify White 3X Widowed 4 □ Divorced 15. Decedent's Education (Spacify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry Baltimore, Maryland 21218 Eiamentary/Secondary (0-12) Collega (1-4or 5+) Housewife Own Home 17. Father's Nama (First, Middle, Last) 18. Mothar's Name (First, Middla, Maiden Sumema) Be 12 should be It and Mental H Emmanuel Coscia Annie Bassett 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Rura! Route Number, City or Town, Stata, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Doris Granruth (daughter) 709 Wampler Road Middle River, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Neme of Date 20c. Location - City or Town, State 1 Buriai 2 Cramation 3 Ramovai from State Oak Lawn Cemetery 9/9/1997 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Furnott Service Licensee Bruzdzinski Funeral Home PA 1407 Old Eastern Ave Essex, Maryland 21221 11. Entar the disease, or complications that caused tha death. Do not entar the mode of dying, such as cardiac or respiratory arrast, hock, or heart failure. List only one causa on each lina. Approximata Interval Betw Onset and Death **Physician** /Medical Immediate Cause (Final Dneumonia disease or condition resulting In death) **Examiner** Examiner The law requires that the death certificate be executed physician end s the burial-transit Sequantially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Diseasa or injury that Initiated avents resulting In death) Last Dua to (or as a consaquence of): P.O. Box 68760. Physician/Medical Dua to (or as a consequence of) use as ate has been signed by the a page 2 should be detached to Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy performed? 2 1 No 1 TYes 2 □ No 25. Was case referred to medical

certificate of Vital or Attending Physician: Be Certification: To After this Division

the funeral director. s after death. in by t To the Hospital o within 24 hours aff To the Funeral Di completely filled in

5 State

Registrar

Medical

29b. Signatura and title of certifiar

28a. Date of Injury (Month, Dey Year)

1 XCertifying Phyaicien: To the best of my knowledge, death occurred at the time, date and placa, and dua to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and mannar stated. 29c. Licensa number 29d. Data signed (Month, Day, Year)

Other: 4 Nursing Home 5 Rasidenca 6 Othar (Specify)

28d. Dascribe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

28. Place of Death (Check only one)

30. Nama and address of person who complated causa of death (Item 23a) (Type, Print)

Panayiotis A. Baltatzis, MD 1232 Race Road Suite 202 Rosedale, MAryland 21237

28c. Injury at Work?

1 Yes 2 No

1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Place of Injury - At home, farm, straet, factory, offica building, atc. (Specify)

28b. Time of

31. Date filed (Month, Day, Year) SEP 0 9 1997

1 ☐ Yes 2 No

5 Pending investigation

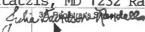
6 Could not be determined

27. Manner of Death 14∑Naturai

2 Accident 3 Suicide

4 Homicide

29a. Certifier



SEP CRIDE

The first of the soulinesses for

State of Maryland / Department of Health and Mental Hygiene 97 27293

3720 FARLAGUT AVE. KENSINGTON MD 20895

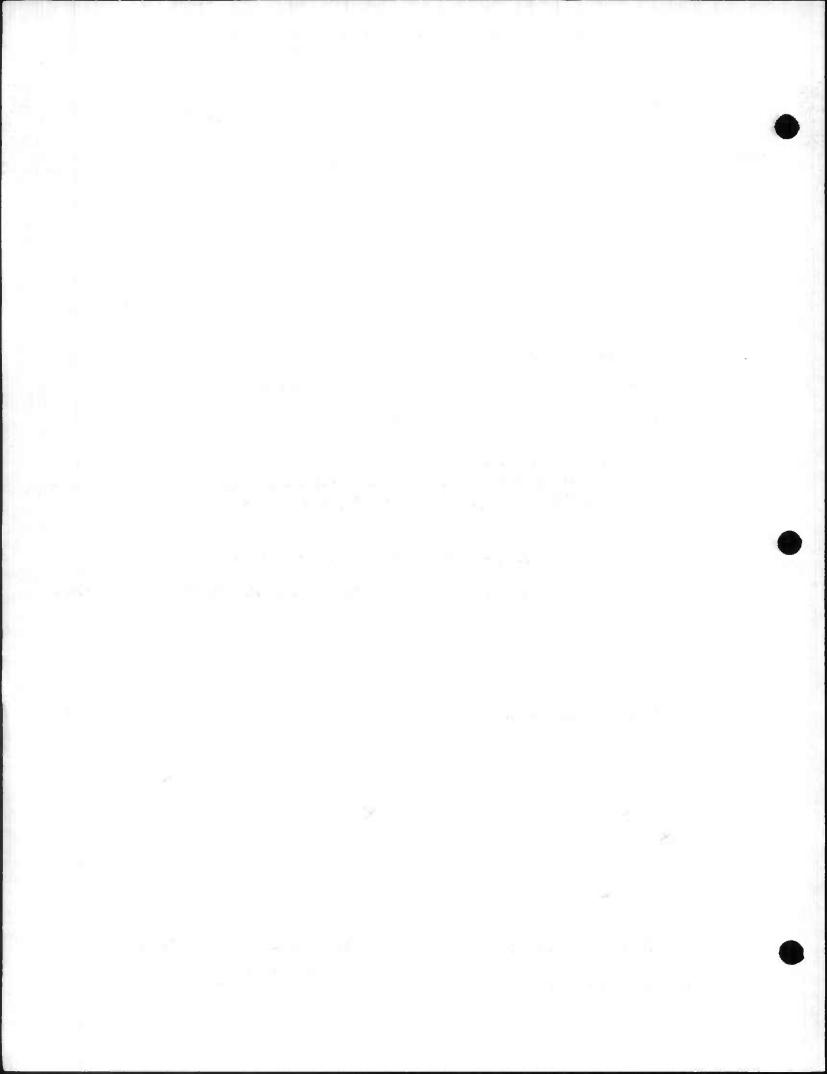
| | | | | Cert | tificate d | of Death | | Reg. No. | F Soreta | 1230 |
|--|------------------|---|---|---------------------------|--|--|---|-------------------------------|-------------------------------|---|
| Physicia /Medic | | 1. Decedent's Name (First, Middle, Le | 1 1 | | | | 2. Dete of De Month AUG | | Ygar | 3. Time of Deeth 5:02 Am |
| Examine Funeral Director | | 5. Social Security Number 6 5 | re street and number) fuspetul Sex 7. Age (In yrs. 1 M 2 A F | last birthday) 7) Yrs. | If Under 1 Ye | ear If Under 24 Hrs | SINI~ 2 8. Date of Bir | - Mo | 9. Birthpla | ace (State or Foreign |
| ms 23a or 28a-1 show | ctor | Usual Residence of Decedent 10a. State M M M M M M M M M | | y, Town or Loca | | | | | 100 | d. Inside City Limits 1 M Yes 2 □ No |
| 23a or 2 | Funeral Director | 10e. Street end Number 3000 McLo. | MAS AVE | | 10f. Zip Cod | 895 | | 10g. Citizen of V | | y? |
| al', or its | þ | 11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Wes Decedent Ever in U, Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give/ Year or Dates: | lf. | es Decedent Yes, specify C | of Hispanic Origin? (S cuban, Mexican, Puer No <i>Specify:</i> | Specify Yes or No to Rican, etc.) | | e - American ck, White, et | lc. |
| ena. then "netural", re Medical Ex | Completed | 15. Decedent's E (Specify only highest gn Elementary/Secondary (0-12) | ducation ade completed) Cotlege (1-4or 5+) | (Give k | ent's Usuel Oc ind of work do O NOT use re | ne during most of wo | rking | 16b. Kind of Bi | usiness/Indu | ustry |
| d oth | To Be Con | unknown 17. Father's Name (First, Middle, Last unknown | unknown | Wai | tress | 18. Mother's Na | | restra , Melden Surnen | | |
| Health end Mer tem 27 is marke other traumatic | | 19a. Informant's Name/Reletionship (unknown | Type, Print) | 19b. Mailing | | eet end Number or R | | er, City or Town, | Stete, Zip C | Code) |
| Department of Has important: If item any Injury or othe phos. | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☑ Other (Specia | Removal from State | lace of Disposi | | | Date | 20c. Location - | City or Tow | n, State |
| nysician Medical kaminer | er | 21. Signature of Fundh LService Licer RODA Ld 13a. Pun 1. Enter the disease, or comports, or heart failure. List only Immediate Cause (Finet disease or condition resulting in deeth) | a. ACUTE M | Do not enter | altimo r the mode of LD/Ac ence of): | re, Maryladying, such as cardia | and 2120 c or respiratory a | 1 nrest, | 1 | Approximate Interval Between Donset end Deeth |
| ing physicie e es the bur | Medical | Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last | C | r es e conseque | ence of): | DiovAscue | AL DIS | EASL | | JEARL |
| igned by the atte | by Physician | Par II. Other eignificent conditions of | | | derfying cause | given In Part I. | | | ntribute to t | the cause of death? |
| has been s | Completed | | | | | | perfe | an autopsy ormed? | com of de | e autopsy findings lable prior to pletion of cause eath? |
| this certificate h | | 25. Wes case referred to medical | | | | OS Piese of Do | 1 - | | 10 | Yes 2□No |
| s certific director, | To Be | exeminer? | Hospitat: 1 ☐ Inpatient 2 ☐ | ER/Outpatient | 3 DOA | Other | eth <i>(Check only i</i> Home 5 □ Resi | one) dence 6 □Oth | er (Snecifu) | |
| E = [| | 27. Manner of Deeth 1 Natural 5 Pending investigatio | 28e. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. l | njury at Nork? | T | how injury occur | | |
| ofter death. Director: After in by the fune | STITIC | 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined | e 28e. Place of Injury - At ho building, etc. (Specify | me, farm, stree | et, factory, offi | ce | 28f. Location (City or To | Street and Numb wn, Stete) | er or Rural I | Route Number, |

Registrar

29b. Signature end title of certifier

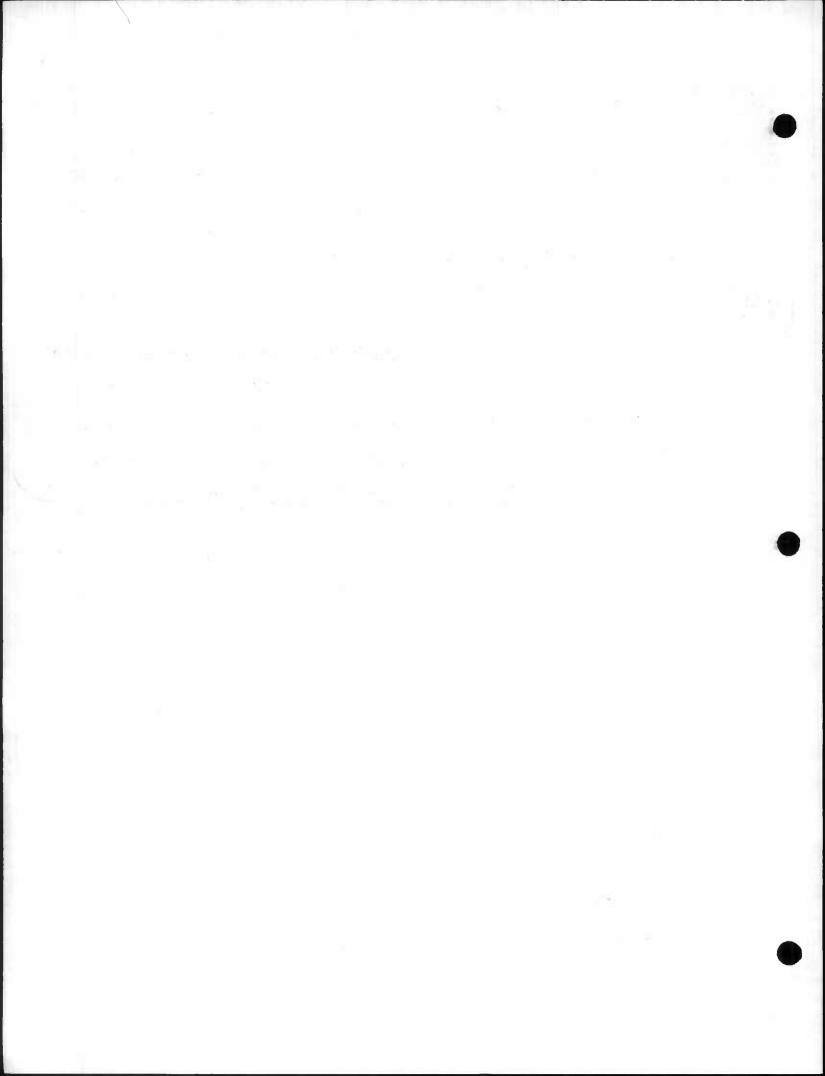
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

SHARGEL M.D.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 2729 [s

| | | | | Otate of Mary | | rtificate of | | | eg. No. | 616 | 94 |
|------------|--|----------------|---|--|--------------------------------------|---|---|---|---------------------------------------|---|-------------|
| | Physic | | Decedent's Neme (First, Middle, Les ROYCE | " C | | EISEN | | 2. Dete of Dee Month | Dey \ | reer 7 | of Deeth |
| | /Medi Examir | | 4a. Fecility Neme (If not institution, give | street end number) | | - 7 | 4b. City, Town, or L | SEPT ocation of Deeth | 4c. County of | 997 ~ Deeth | , , |
| 7 | 220 | | 6300 red Cedar F | Place Ant 3 | 12 | | DATES | MODE | NT / | | |
| 4 | Funeral Director | | 5. Sociel Security Number 6. Se | | rrs. lest birthday) | If Under 1 Year Months Deys | BALTI If Under 24 Hrs Hours Min. | 8. Date of Birth (Month, Day DEC • 26 | Year) | Birthplece (State Country) MARYLANI | |
| | P A | | 10a. Stete 10b. County | 10c. | City, Town or Lo | ocation | | | | 10d. Inside | City Limits |
| | with the Maryland a or 28a-f show be notified at | Director | MD N/A | | BAI | TIMORE | | | | | s 2 No |
| | De no | Dire | 10e. Street end Number | | | 10f. Zip Code | | 1 | 0g. Citizen of Wh | ef Country? | |
| | e 23a | la l | 6300 RED CEDAR PI | | | 2120 | | | USA | | |
| 020 | H | by Funeral | 11. Maritel Stafus 1 ☐ Never Married 2 ☐ Merried 3 ☑ Widowed 4 ☐ Divorced | 12. Wes Decedent Ever In Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: | | Was Decedent of Hilf Yes, specify Cube 1☐ Yes 2☐X0 | lispento Orlgin? (Sp en, Mexicen, Puerto Specify: | pecify Yes or No- Ricen, etc.) | | American Indian, White, etc. WHITE | |
| 1,650 | | Sleted | 15. Decedent's Edu (Specify only highest gred | le completed) | (Give | dent's Usuel Occup kind of work done DO NOT use retired | during most of world | king | 16b. Kind of Busi | ness/Industry | 49.5 |
| 213 | The state of | Comp | Elementery/Secondery (0-12) | College (1-4or 5+) | ADM: | INISTRATI | VE SPECIA | LIST | SOC. SEC | CURITY AI | MN. |
| Pu | offish offish vent, | Be C | 17. Fether's Neme (First, Middle, Last) | | | | 18. Mother's Nam | e (First, Middle, | Maiden Sumame) | | |
| Maryland | Ments Ments ankad attic e | To | BENJAMIN | | BONDY | | BERTH | IA | LE | VINSON | |
| Mar | 2 sh a ra is m | | 19e. Informent's Neme/Relationship (T) | | | ng Address (Street | | | | | |
| | 1 and Health 8m 27 ther t | | BONNIE FRANKLIN 20e. Method of Disposition | • | | HIGHMEAI | XXW RD. | | TOWN, MD 20c. Location - Ci | | |
| Baltimore, | nit. Pages artment of ortant: If its injury or o | | 1√Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donetion 5 ☐ Other (Specify) | Removel from State | cemetery, cre BETH TF: | metory or other plea | 1 | 7/97 | | MORE, MD | |
| Balt | permit. Departs Imports any injudence | 13 | 21. Signature of Funeral Service Liceage | 9 | | 2. Name end Addre | ss of Fecility | | • | | |
| | _ | - | 23a. Partt: Enter the disease, or comp shock, or heart failure. List only o | ications the caused the d | eeth. Do not en | 8900 REIS | TERSTOWN | RD., PI | KESVILLE | | |
| | Physician | | shock, or heart failure. List only o | ne cause on each life. | | | | | | Approxim Intervel B Onset end | d Deeth |
| 7 | /Medical | | Immediete Ceuse (Finel disease or condition | | - HRO | VIC 1 | RENAL | FAT | LURE | 12 YA | 00 |
| | Examiner | | resulting in death) | e. Due to | o (or es e conse | VTC 1 quence of): ARTRO | 40,110 | | | | |
| | pe is | lne | | Cope | VARY | RETER | ey Di | ISEA. | SE | 10 YR | 25 |
| | ficate be executed physician end is the bunel-transit | Examiner | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to | o (or es e conse | quence of): | | | | | |
| 68760, | sician bunie | | ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events | C | / | | | | | | |
| | E 00 60 | Medical | resolding in deeth) Lest | | o (or es e consec | quence oi): | | | | | |
| Вох | deeth cer e attendir ed for use | Physician/W | | d | | | | | | | |
| <u>o</u> | the deerly the a | /slc | Pert II. Other significant conditions co | ntributing to death but not | resulting in the u | inderlying ceuse giv | en in Pert I. | 23b. Did to | bacco uee contr | ibute to the cause | of death? |
| Δ. | that ed b deta | by Ph | | | | | | 1 🗆 Y | es 22No 3 | Probably 4 | Unknown |
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| Vital | Physician: The this certificate ral director, page | Be | 25. Wes case referred to medical exeminer? | | | | | th (Check only or | (ө) | | |
| of | hysic this o | 2 | T Tes | | ER/Outpatie | | 4 Nursing H | | ence 6 Other | | |
| | Attending For death. | atlon: | 27. Menne-of Deeth Salural 5 Pending investigation | 28e. Dete of Injury (Month, Dey Year | 28b. Time of Injury | Wor | y et k? Yes 2 □ No | 28d. Describe h | ow injury occurred | | |
| Division | 3 4 5 5 | Certification: | 3 Suicide 6 Could not be determined | 28e. Place of Injury - A building, etc. (Spe | t home, ferm, st | reet, fectory, office | | 28f. Location (Si City or Town | | or Rurel Route Nu | mber, |
| | To the Hospital or within 24 hours after To the Funeral Dir completely filled in | edical (| 29a. Certifier Check only one) Certifying Phy 2 Medical Exami | elclan: To the best of my liner: On the basis of examend menner steted. | knowledge, deat inetion end/or in | h occurred et the tir vestigetion, in my o | ne, dete end plece, pinion, deeth occur | end due to the c red et the time, d | ause(s) and menr ete end plece, en | er es stated. d due to the ceuse | (s) |
| | Within To the | Me | 29b. Signeture end title of certifier | , | | 29c. Licens | e number | 2 | 9d. Dete signed (| Month, Dey, Year) | |
| | | | 15/18W | M | | DI | 9317 |) | 9/5 | 175 | |
| | 4 | | 30. Neme and eddress of person who co | ompleted cause of deeth (I | tem 23a) (Type, | Print) 2 (DFG_16 | TREE A | & BAI | TTOO | E DO | 2202 |
| | Sta | te | 31. Dete filed (Month, Dey, Year) | 32 Registrer's Si | gnature | | 11-0- 1. | | 1 4 6 | 10.002 | 7 000. |
| | Registr | | SED 0 0 1007 | Julia Daine | 1. 10.1 | 00 | | | | | |



State of Maryland / Department of Health and Mental Hygiene 97 2

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Daath 3. Time of Death Month **Physician** AUG 1997 1020 AM ALLEN ETHEL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Good Samaritan Hospital Baltimore Baltimore City If Under 1 Year 5. Social Security Number If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) **Funeral** Days Months 1□M 2QF 217-30-3573 Yrs. Director Jan. 6, 1906 N. Carolina Usual Rasidence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumetic event, the Medical Examinar must be notified at Maryland Baltimore City Baltimore Director 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1217 Glenwood Avenue 21239 death U.S.A. Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indien, Black, White, etc. permit. Peges 1 end 2 should be filed within 72 hours efter Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural; or item any injury or other traumatic event, the Medical Exercise. 1 Never Marriad 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) unknown unknown Homemaker Own Home 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Neicey Payne Forman Payne 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Davis/neice 1217 Glenwood Avenue, Baltimore, Maryland 21239 20b. Piace of Disposition (Name of 20a Method of Disposition Date 20c. Location - City or Town, Stete cametery, crematory or other plece) 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 □Other (Specify) Director 22. Name end Address of Fecility State Anatomy Board, 655 W. Baltimore Street Service Licensee While Baltimore, Maryland 21201 23a. Part. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shape, or haar failure. List only one cause on each line. Approximete Intarval Between Onset end Death **Physiclan** immediata Causa (Final disease or condition resulting In death) /Medical Sepsis **Examiner** Due to (or as a consequance of): Examiner sician and buriel-transit Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Causa (Disaasa or Injury Due to (or as e consequence of) certificate be exec P.O. Box 68760. attending physician for use es the burie Physician/Medicai that initiated events resulting in death) Lest Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed by Records, by 8 24b. Ware autopsy findings available prior to completion of cause of daath? page 2 should Completed 24a. Was an autopsy peed certificate hes 1 Yes 2 No 1 Yas 20 No Division of Vital Be 25. Was casa referred to medical 26. Piaca of Death (Check only one) Othar: 4 Nursing Home 5 Residance 6 Othar (Specify) 1 12 Inpatient 1 Yas 2 No To 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how Injury occurred Attending 5 Panding investigation 1 Naturai death. 1 Yes 2 No 2 Accident filled in by the To the Hospital or Attend within 24 hours efter death To the Funeral Director: 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica bullding, etc. (Specify) 4 D Homicide 1 Cartifying Phyalcian: To the best of my knowladga, daath occurred at the time, date and place, and due to the cause(s) and manner as stated.

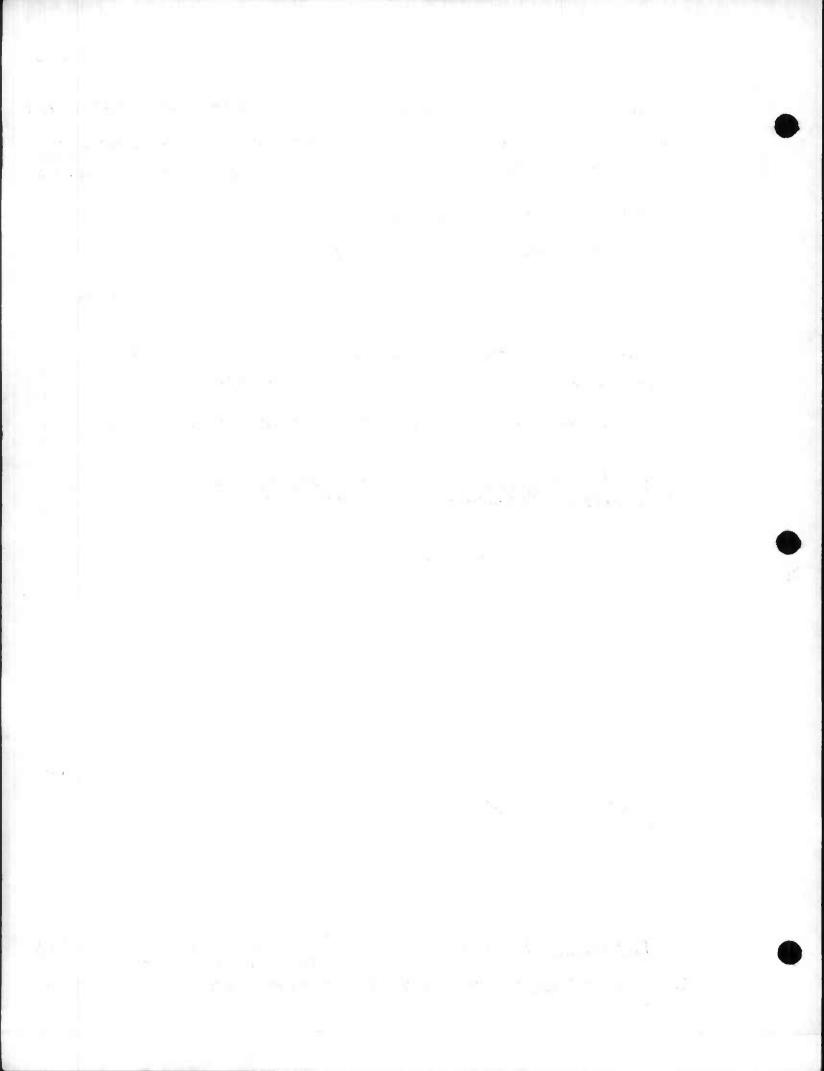
2 Medical Examinar: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and placa, and dua to the causa(s) and manner stated. edicai 29a, Certifian 29b. Signature and title of certifier PI0579 29d. Date signed (Month, Day, Year) 0579 AUG. 23, Balti, mo 21239-2995 Adniana Andrade, mp P10579 Aug. 23. 199.

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) Balt, mp 21239-2795

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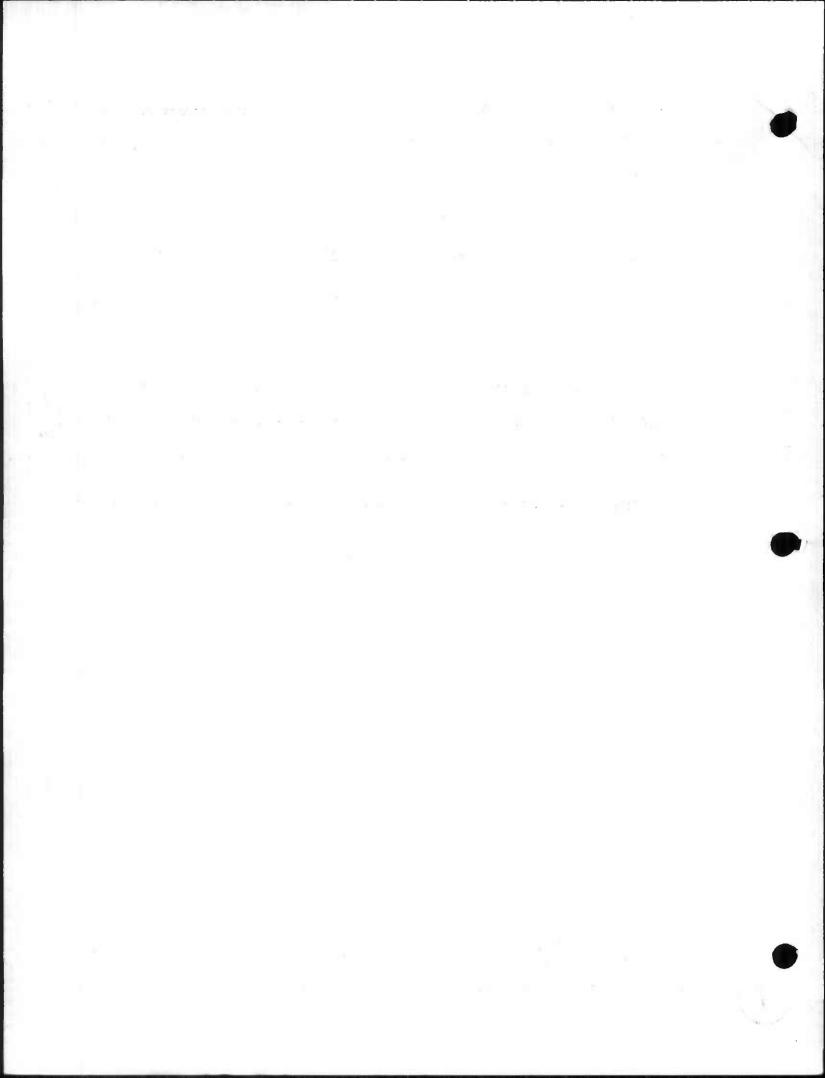
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| Father's Name (Pints, Models, Last) Samuel L. Franklin Samuel L. F | KAN S | S with Sone. | omp | | | 5+) | | | | -, | | Facto | ry | |
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| Due to (or as a consequence of): Continue | S | e axecuted lan and unal-trans | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b | Dua to (o | r es e con | sequanca of): | | | | | 1 | |
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| Hypertension, Peptic Ulcer 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to complete to occupied to death? 1 Yas 2 No 1 Yas 2 No 1 Yas 2 No 1 Yas 2 No 1 Yas 2 No 1 Yas 2 No 1 Yas 2 No 1 Yas 2 No 1 Yas 2 No 1 Yas 2 No 1 Yas 2 No 1 Yas 2 No 1 Yas 2 No 1 Yas 2 No 1 Yas 2 No 1 Yas 2 No 1 Yas 2 No 1 Yas 2 No 2 No No No No No N | | | ysic | Part li. Other eignificant conditions | contributing to death b | out not rasu | uiting in th | a undarlying o | ausa giv | van in Part I. | 23b. Dld | tobacco use co | ntribute to the | cause of death? |
| 29a. Cartifier (Check only one) 29a. Cartifier (Check only one) 29b. Signatura and title of certifier 29c. Licansa number 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Nama and address of person who compiated cause of death (item 23a) (Type, Print) Marcos Galicia, MD 9600 North Point Road Fort Howard, MD 21052 State 29a. Cartifier (Check only one) 12 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and piace, and dua to the causa(s) and mannar as stated. (Check only one) 29b. Signatura and title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Nama and address of person who compiated cause of death (item 23a) (Type, Print) Marcos Galicia, MD 9600 North Point Road Fort Howard, MD 21052 31. Determine the filled (Month, Day, Year) B2, Registuar's Signature | ٥ | es that the igned by be detact | by Ph | Chronic Obstr | ructive P | ulmo | nary | Dise | ase | 2, | 10 | Yee 2□ No | 3 Probabl | y 4□Unknown |
| 29a. Cartifier (Check only one) 29a. Cartifier (Check only one) 29b. Signatura and title of certifier 29c. Licansa number 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Nama and address of person who compiated cause of death (item 23a) (Type, Print) Marcos Galicia, MD 9600 North Point Road Fort Howard, MD 21052 State 29a. Cartifier (Check only one) 12 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and piace, and dua to the causa(s) and mannar as stated. (Check only one) 29b. Signatura and title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Nama and address of person who compiated cause of death (item 23a) (Type, Print) Marcos Galicia, MD 9600 North Point Road Fort Howard, MD 21052 31. Determine the filled (Month, Day, Year) B2, Registuar's Signature | 2100 | aw requi | pieted | Hypertension, | Peptic | Ulce | r | _ | | | 24a. Was perio | an autopsy omed? | availab | la prior to |
| 29a. Cartifier (Check only one) 29a. Cartifier (Check only one) 29b. Signatura and title of certifier 29c. Licansa number 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Nama and address of person who compiated cause of death (item 23a) (Type, Print) Marcos Galicia, MD 9600 North Point Road Fort Howard, MD 21052 State 29a. Cartifier (Check only one) 12 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and piace, and dua to the causa(s) and mannar as stated. (Check only one) 29b. Signatura and title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Nama and address of person who compiated cause of death (item 23a) (Type, Print) Marcos Galicia, MD 9600 North Point Road Fort Howard, MD 21052 31. Determine the filled (Month, Day, Year) B2, Registuar's Signature | a | The i | Som | | | | | | | | 10 | Yas 2 No | 1 □ Ya | s 25 No |
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| Marcos Galicia, MD 9600 North Point Road Fort Howard, MD 21052 State 31. Deterfiled (Month, Dey, Year) 82, Registar's Signature | .2 | or after after Directory | erti | 4 ☐ Homicide detarmine | building, at | c. (Specify | y) | street, lactory | , unice | | City or To | wn, Stata) | 301 07 110107110 | ota manibor, |
| Marcos Galicia, MD 9600 North Point Road Fort Howard, MD 21052 State 31. Deterfiled (Month, Dey, Year) 82, Registrar's Signature | | Hospita 24 hours Funeral etely fille | | Check only 2 Madical Exi | iminer: On the basis of | f axaminat | wiedga, da tion and/or | aath occurred r invastigation | et tha tir in my c | ma, data and piace, ppinion, daath occurr | and dua to tha ed at tha tima, | causa(s) and m data and piace, | annar as stated and dua to tha | i. cause(s) |
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| 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Marcos Galicia, MD 9600 North Point Road Fort Howard, MD 21052 State 31. Dete filed (Month, Dey, Yeer) \$2, Registuar's Signature | | r s r ö | | 1 | /- | 0 | | 1 |) , (| -166 | | < + | 5.100 | 7 |
| Marcos Galicia, MD 9600 North Point Road Fort Howard, MD 21052 State Marcos Galicia, MD 9600 North Point Road Fort Howard, MD 21052 State Marcos Galicia, MD 9600 North Point Road Fort Howard, MD 21052 | | and the second | | 30. Nama and address of person who | LA LOS | | 1 23a) (Tvr | pe, Print) | //3 | 070 | | sil. | -1117 |) |
| State 31. Dete filed (Month, Dey, Yeer) 62, Register's Signature | 1 | 79 | | | | - | 7.5 | | tR | Road For | t Howa | rd. MD | 210 | 52 |
| The state of the s | (1 | | te | 31. Dete filed (Month, Dey, Year) | 82 Regists | ar's Signal | tyre | | | | | | | |

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State of Maryland / Department of Health and Mental Hygiene

97 2729

Certificate of Death 1. Dacedent's Neme (First, Middle, Last) 2. Date of Deeth **Physician** SEPT. Dey 1997 5, 11:46 AM Joseph NMN Favarola /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5505 KNELL AVENUE BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funerai** Days Hours 1X M 2□ F Yrs Director 213-07-2559 92 Italy May 10,1905 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Directo Maryland N/A Baltimore 10e Street and Number 10f. Zip Code 10n Citizen of What Country? 21206 U.S.A. 5505 Knell Funeral Avenue 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Raca - Amarican Indian, Bieck, White, etc. Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 should be filled within 72 hours after ond Mentel Hygiene. Is marked other than "naturel", or its 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: by 3 Widowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 18e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steel Company 3rd. Grade Steel Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Vito NMN Favarola Petrina **NMN** 19a. informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 end 2 st Department of Health end Important: if item 27 is n any injury or other traun 21084 Jarrettsville, MD Vito Angelo Favarola / Son 1820 Trout Farm Road 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dete X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/9/1997 Holy Redeemer Cemetery Baltimore, MD 21. Signature of Fugeral Service Licenses 22. Name and Address of Facility John C. Miller, Inc. 6415 Belair Road 21206 Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Daath **Physician** Immediate Ceuse (Finel CONTACT GUMSHOT WOUNDOF HUDD disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner ician and bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Lest Due to (or as a consequence of): physician s the buna Box 68760 99 Physician/Medical Due to (or as e consequence of): ettanding Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? O 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of causa of death? 24a. Wes an eutopsy performed? Completed 14200 only 1 Yes 2 No Division of Vital 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient 2 | ER/Outpetient 3 | DOA Other: 4 ☐ Nursing Home XXI Residence 6 ☐ Other (Specify) 1 Yes 2 No funeral 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how Injury occurred Hospital or Attending P 124 hours after death.
 Funeral Director: After t 28c. Injury at Work? Aftar 1 Natural 5 ☐ Pending Surspor SHOT SELF. FOUND 112M 1 ☐ Yes 2 1 No investigation 597 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 ☐ Homicide filled in 5505 KUELLAUE BALMORS LYD RESIDENCE • Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and piece, and due to the ceuse(s) end manner as stated. To the Hosp within 24 ho To the Fune complately fi (Check only one) 2XXMadical Examinar: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) end menner steted. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SEPT. 6, 1997 O.C.M.E 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) A KOREL 111 Penn Street, Baltimore, Maryland 21201 MARYSONA

State Regi<u>strar</u> 31. Date filed (Month, Day, Year)

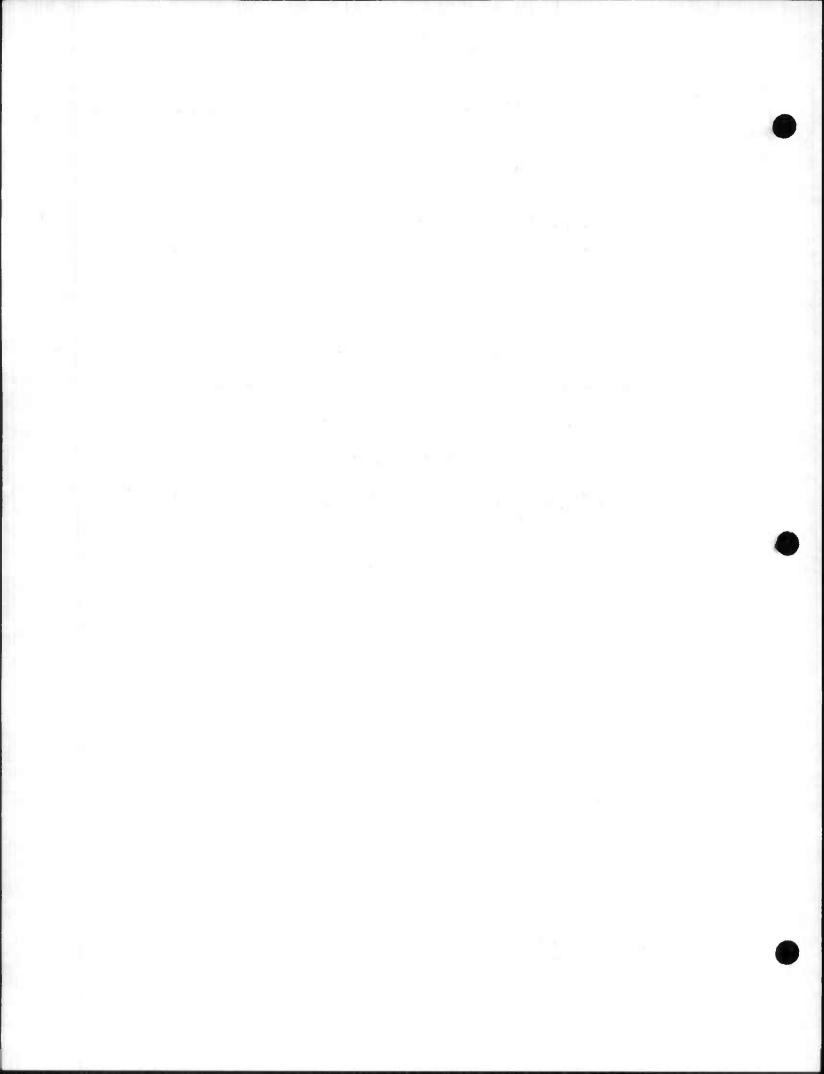
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32. Registrar's Signature

Julia Davidson

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 27298

| | | | | | | | Cer | tifica | te of l | Death | | Reg. No. |) | 1 4 | 1230 |
|---|----------------|-----------|--|-----------------------|--|----------------------|-----------------------------------|--------------|---------------------|------------------------------|--|--------------|------------|---------------------------------|-------------------------------|
| | | | 1. Decedent's Name (First, | Middle, La | st) | | | | | | 2. Date of D | eath | | | Time of Death |
| Phys /Me | iciar dica | _ | Marilya | | Foul | ds | | | | | Month Sector | Day | rutes and | Year | 1:55 pm |
| Exar | | - | 4a. Fecility Name (If not inst | itution, giv | | | | | 4 | b. City, Town, or | Location of Dea | | - | of Death | 1 |
| 0 | | ľ | The Johns | 1400 | ekins He | J. OSC | la | | 5 | southers | ~~ | | n/a | 1 | |
| Funer | al | | 5. Social Security Number | 6. S | ex 7. A | | last birthday) | If Unde | or 1 Year Days | If Under 24 Hrs Hours Min | | irth | | 9. Birthplace | (State or Foreign |
| Direct | or | | 208 40 2950 | 1 | □M 2₩ F | 46 | Yrs. | MOHINS | Days | Hours Mile | 8. Date of B (Month, C | 195 | 0 | ARKANS. | AS |
| pu , | | - 1- | Usual Residence of Decede | | | 1 | | | | | | | | | |
| anyla | | | 10e. State 10b. C | ounty | | 10c. Cit | y, Town or Loc | ation | | | | | | | nside City Limits |
| No M | 3 | 2 | PA NOR | 'HUMB | ERLAND | | DALMA | ΓIA | | | | | | 1 | Yes 2 No |
| # # 2 × 2 × 2 × 2 × 2 × 2 × 2 × 2 × 2 × | Director | | 10e. Street and Number | | | | | 10f. Zi | p Code | | | 10g. Citiz | en of W | /hat Country? | |
| 23a | 0 | | RD #1 Box 2 | 225 | | | | | 170 | 17 | | US | A | | |
| 72 hours after death with the Manyland natural; or items 23s or 28s-f show sical Examples must be notified at | 9 | runerai | 11. Marital Status | | 12. Was Deceden Armed Forces | t Ever in U. | ,S. 13. W | as Dece | edent of Hi | spenic Origin? (| Specify Yes or N rto Rican, etc.) | 0- 1 | | - American In k, White, etc. | dian, |
| afte a | Li S | | 1 Never Married 2 | | 1 Tyes 2 Y | No | | | | Specify: | , | | Specify: | 1.711 | ITE |
| Sours Fig. | Î | 200 | 3 ☐ Widowed 4 ☐ Div | orced | Year or Dates | | | | | | | | Specify. | | |
| d within 72 hours afgiene. If than "natural", or | 100 | Completed | 15. Dec (Specify only l | edent's Ed | fucation de completed) | | 16a. Decede (Give k | ent's Usu | al Occupa | ation furing most of wo | orking | 16b. Kir | nd of Bu | siness/industry | / |
| d within jiene. r than "r | 8 | | Elementary/Secondary (0 | 12) | College (1-4or | 5+) | life. D | | | | | 0- | | 1 | |
| | | | 12 | 1.41 - 1 1 | n/a | | | Sear | mstre | | | - | | t Indu | stry |
| be filed tal Hyg d other | a | ŏ | 17. Father's Name (First, Mi Burl F | | | | | | | | ame (First, Middle | , Maiden S | Surnam | 9) | |
| d 2 should be file th and Mental Hy 7 le marked othe treumatic event. | F | | | | | | | | | | ta Rose | | | | |
| d 2 should h and Mer 7 le marke treumatic | | | 19a. Informant's Name/Rela | itionship (| Type, Print) | | 19b. Mailing | g Addres | s (Street a | and Number or R | Rural Route Num | ber, City or | Town, | State, Zip Code | в) |
| | | - | Marlin F. H | ould | S | | | | | 5, Dalm | atia, PA | | | | |
| t. Pages 1 an timent of Heal tent of Other other tent of Other | | 1 | 20a. Method of Disposition N□ Burial 2 □ Crema | tion 3 🗆 | Removel from State | C | Place of Dispos cometery, crem | atory or | other plac | | 9 Sept. | 20c. Loc | cation - | City or Town, S | State |
| Deput Pages 1 are Deput Pages | | 1 | 4 ☐ Donation 5 ☐ Oth | er (Specify | y) | Nor | thumber | rland | d Mem | .Park | 1997 | Sunbi | irv. | PA. | |
| | once | 4 | 21. Signature of Funeral Se | 4 | | D | | | | s of Fecility | | | | | |
| 205 | a/ | | OWNER | Let | THOM | do | | emmoi | n Fun | eral Ho | me of Du | lane | y Va | lley, | Inc. |
| 100 | | 7 | 23 Part Enter the disease shock, or heart failure. | er, or com | olications that cause | d the death | h. Do not ente | r the mo | de of dyln | nla Ko. g, such as cardia | ac or respiratory | ım , Mi | 0-41 | .093 App | roximate |
| Physicia | n | | arraves or reserving | can only | One cause on each | iii io. | | | | | | | | Ons | rval Between set and Death |
| /Medica | - | | Immediate Cause (Final disease or condition | | | | | | | | | | | | |
| Examine | er | | resulting in death) | | · coed | | r as a consequ | | | -27 | | | | 103 | tou. |
| n & | ě | 5 | | | | | | | | | | | | 1 | |
| be executed lician and burial-transit | Examiner | | Sequentially list conditions. | • | a bayes | | ds a consequ | | 031 | 5967 | | | | - 1 | eas |
| de se | | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Olsease or Injury that initiated events. | J | \ \ \ | _ | | and the same | | | | | | l. | |
| certificate be exe iding physician a ise as the burlai- | edical | 3 | Cause (Disease or Injury that initiated events resulting in death) Last | 5 | c ide | Due to (or | as a consequ | ence of): | | | | | | 17 | Year |
| arillica ing ph | Pen | 2 | resulting in destry Less | | | | 3 | | | | | | | | |
| ath car attendin for use | | | | - | d. | | | | | | | | | - | |
| death e atter | Physician | 2 | Part II. Other significant co | nditiona co | ontributing to death | but not resu | ulting In the un | derlylna | cause give | en in Part I. | 23b. Dio | tobacco i | use con | tribute to the | cause of death |
| that the detected | Š | | | | | | | , | | | | | | | 4 Unknow |
| es that igned b | 20 | | | | | | | | | | | | | , | |
| 0 0 = C | | | | | | | | | | | 24a. Wa | s an autop | sy | | utopsy findings |
| law requests been 2 should | Completed | 1 | | | | | | | | | pen | ormed? | | complet of death | e prior to tion of cause |
| The lay ate has page 2 | E | | | | | | | | | | 100 | 200 25 | No | 1 ☐ Yes | |
| | | | 25. Wes case referred to me | dicat | | | | | | 00.00 | 11. (2) | | 1140 | I LI Tes | 2 LJ NO |
| | o Be | | examiner? | Joan | Hospital: | iont of | ED/O | 9 CT E | Office | ar' | eath (Check only | | По: | . (04 | |
| | T. | | 27. Manner of Death | | 28a. Date of Ini | | ER/Outpatient 28b. Time of | | UA | 4 LI Nursing | Home 5 ☐ Res 28d. Describe | | | | |
| ding Ph h. After thi funeral | tion. | | 1 ☐ Natural 5 ☐ P | ending vestigation | 28a. Date of Inj (Month, D | ay Year) | Injury | М | 28c. Injury Work | (? Yes 2 □ No | | | | | |
| or Attending after death. Director: After | lica Ecil | 2 | 3 Suicide 6 □ C | ould not be | | iun - At ho | me ferm stre | | | | 28f Location | (Street and | 1 Numbe | er or Rurel Rou | ite Number |
| or Attendate of Director: | Certification: | 5 | 4 ☐ Homicide | etermined | building, e | c. (Specify | y) | or, idotor | y, 011100 | | City or To | wn, State) | ,,,,,,,,,, | | 10 110111001 |
| lospital I hours uneral sly filled | | | 29a. Certifier 1 Cer | tihdaa Dh | uelolea . To the boot | of mu know | uladaa daath | | l at the time | n data and nice | a seed due to the | | | | |
| | edical | 5 | (Check only 2 Mec | Ical Exam | yalctan: To the best liner: On the basis and manner s | of exa <i>m</i> inat | tion and/or inve | estigation | n, In my op | oinion, death occ | a, and due to the urred at the time | date and | plece, a | nd due to the | cause(s) |
| To the I- within 2- To the F complet | 2 | | 29b. Signeture end title of ca | rtifier | and mainler's | idibu. | - | 29 | c. License | number | | 29d. Date | slaned | (Month, Day, | Year) |
| F 3 F 8 | | | 11 | , 1 | 7 1 | | | | | | | | | | |
| 10 | , | - | Dunly | 1 th | ucka | | | | 000 | 52133 | | Sept | emb | 1,2 2m | 7997 |
| 10 | | 3 | 30. Name and address of pe | rson who d | completed cause of | death (Item | 1 23e) (Type, P | | | | | , | | | |
| | | | The Johns | 14 | ofking 1 | tospi | hat | Ba | 74-200 | ire, pr | vary loss | 1 0 | 5138 | F | |
| \$ | State | | SFP 0 9 1 | (ear) | 32. Regist | rar's Signa | HELDE | | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. ITEM: 5 per FH G-752 10-State of Maryland / Department of Health and Mental Hygiene Item1.6a 9-9-97FilmG751 W.H.Per F/H Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Death 06. 1997 **Physician** 45 SEP KEBECCA /Medical AM 4a. Facility Nama (If not institution, giva streat and number) 4h City Town or Location of Death 4c. County of Death Examiner LEVINDALE BALTIMORE 5. Social Security Number 217-03-9514 If Undar 1 Yaer If Undar 24 Hrs. 8. Data of Birth 7. Age (In yrs. lest birthday) 9. Birthplaca (Stata or Foraign **Funeral** Days 1 □ M 2 🛱 F 84 MARYCAND Yrs. Director 9415-a Usuai Rasidence of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits MARYLAND BALTIMORE BALTIMORE 1 ☐ Yes 2 ☑ No Director 10f. Zip Coda 10g. Citizen of What Country? fural", or items 23s or al Examiner must be r 7936 DUNHILL VILLAGE CIRCLE, APT. 202 21244 USA 238 Funeral 12. Was Decedent Ever In U,S. Armed Forces 1 ☐ Yes 2 ☐ No If Yas, Giva Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race · Amarican Indian, Black, White, etc. 1 Never Merried 2 Merried 1□ Yes 2□ No WHITE Specify: à 3 Widowed 4 Divorced 18a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Beautician BEAUTUCIAN 12 BEAUTY SHOP 17. Fathar's Name (First, Middle, Last) HARRY 18. Mothar's Name (First, Middle, Maiden Sumeme) FREED SOPHIA **MEYERS** 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rurel Routa Number, City or Town, Stata, Zip Coda) GRACE FREED (SISTER) 7936 DUNHILL VILLAGE CIRCLE, APT. 202 BALTO., MD 21244 20b. Plece of Disposition (Nama of 20c. Location - City or Town, State 20a. Mathod of Disposition ± 0 cematary, crematory or other place)
ARLINGTON-CHIZUK AMUNO- 9-8-1997 BALTIMORE, MD 1 2 Burial 2 Cramation 3 Ramoval from Stata b 4 ☐ Donation 5 ☐ Othar (Specify) of Funarai Service Heensel 22. Name and Address of Facility
SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part1. Entar tha diseasa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervsi Batween Onset and Death **Physician** End slege Dement a

Dua to (or as a consequence of):

Carelynumber accident Immediata Causa (Final diseasa or condition rasulting in daath) /Medical Examiner physician and s the bunal-trans Sequentially list conditions, if sny, leading to immadiata causa. Entar Undarlying Cause (Disaase or injury that initiated evants resulting in daath) Last Nyvestension Physician/Medical ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 1 Yes 2 No 3 Probably 4 Unknown p 24b. Wara autopsy findings available prior to compiation of cause of death? 24a. Wes en sutopsy performed? Completed has 2 No 1 ☐ Yas 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 25. Was case rafarred to medical axaminar? Be 28. Place of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28c. injury at Work? Certification: 28b. Tima of 28d. Dascribe how injury occurred 5 Panding invastigation 1 Maturai 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcida 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 Homicide 24 hours 1 Contitying Physicien: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the best of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the Hosp within 24 hou To the Fune completely fil Medical and mannar steted. 29c. Licensa number 29b. Signature end title of certifian

Division of Vital Records, P.O. Box 68760,

31. Data filed (Month, Day, Year) SEP 0 9 1997

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1 acu.

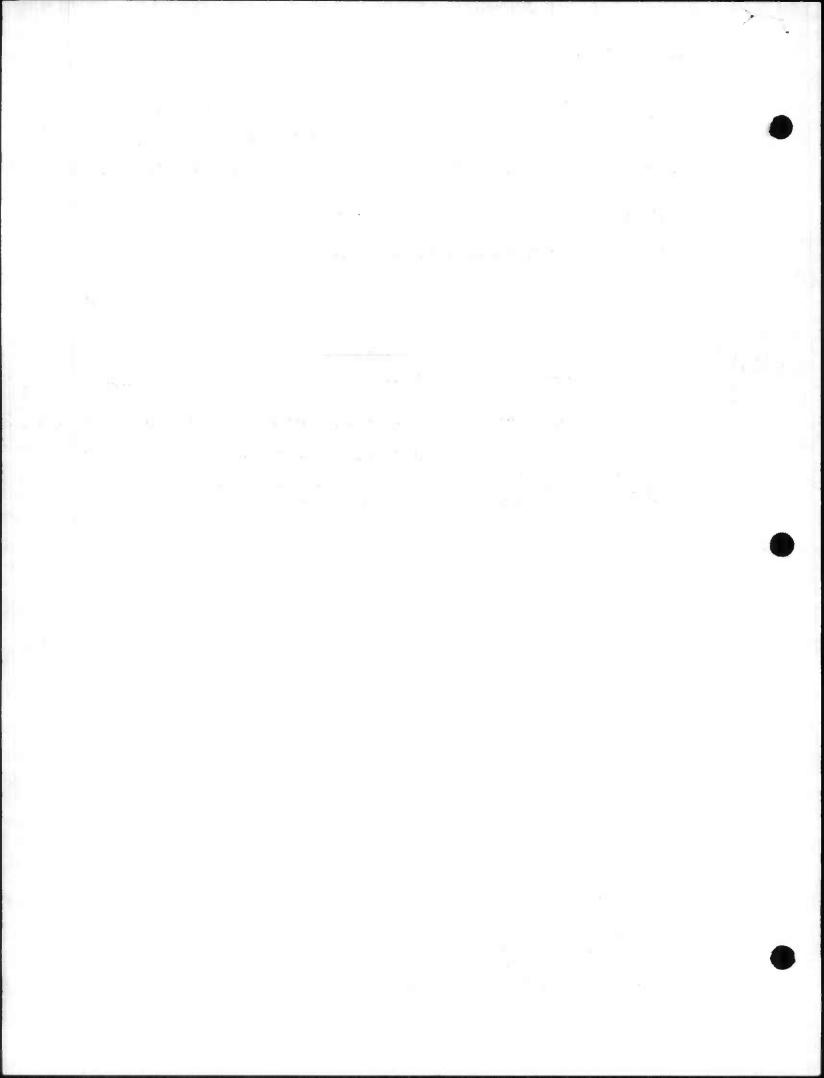
30. Nama and addrass of person who complated cause of death (itam 23a) (Type, Print)



F1844

State

Registrar



| 11 | | | State | oi iviaryiar | | | of Health and Food of Death | Mental Hy | /giene 9 | 1 2 | 7300 |
|---|-----------------|--|--|---|-------------------------|--|--|--|------------------------------------|----------------------------------|---|
| Phys | | 1. Decedent's Name (First, Middle, I | Grave | er | | | | 2. Date of D Month | Day | 947 | 3. Time of Death |
| | dical niner | 4a. Facility Name (If not institution, g | nive street and nu | mber) | | | | r Location of Dea | th 4c. County | | |
| Funer Direct | _ | 067-10-9842 | Sex 1⊠XM 2□ F | 7. Age (In yrs. 87 | last birthday) Yrs. | If Under 1 Y Months Da | Baltimo ear If Under 24 Hi ays Hours Mi | 8. Date of Bi (Month, D | Not th ay, Year) 23, 1910 | 9. Birthplac Country, | e (Stete or Foraign) .a |
| ahow ahow | | Usual Residence of Decedent 10a. State 10b. County | | 10c. Ci | ty, Town or Lo | cation | | | | | Inside City Limits |
| fin with the Maryla 23a or 28a-f show sist be potified at | Director | Maryland None | | В | altimo | re | de | | 10g. Citizen of | What Country | 1 ☐XYes 2 ☐ No |
| A with | | 2434 West Belvede | ere Aven | ue | | 2121 | | | U.S.A | | |
| Sample Complete | by Funeral | 11, Marital Status 1 □ Never Maπied 2 ★ Married 3 □ Widowed 4 □ Divorced | Armed F | 2 No ive | | Was Decedent f Yas, specify (1 ☐ Yes 2⁄2) | of Hispanic Origin? (Cuban, Mexican, Pue No <i>Specify:</i> | Specify Yes or Norto Rican, atc.) | | ca - American ck, Whita, etc. | |
| 2121 -0 d within 72 giern. r than helling the Medical 3 | Completed | 15. Decedent's (Specify only highest of Elementary/Secondary (0-12) | Education grade completed) College (| | (Give | DO NOT use re | one during most of w | orking | 16b. Kind of B | | |
| be file tal Hy d othe event. | Be | 12 Years 17. Father's Name (First, Middle, La | st) | | Welde | r | | ame (First, Middle | , Maiden Surnan | tructio | on |
| Aarylar 2 should b 3 and Manta 1s marked rsumatic e | 7 | Charles Graver 19a. Informent's Name/Relationship | (Type, Print) | | 19b. Mellin | ng Address (St | reet and Number or I | a Rabino | | Stete, Zip Co | ide) |
| | | Julius J. Eingor 20a. Mathod of Disposition 1 Rurial 2 Cremation 3 | ☐Removal from | 20b. I | Placa of Dispo | 7 71st sition (Name on natory or other | Avenue, F | Date | 20c. Location | City or Town, | , Stete |
| Baltimore, permit. Pages 1 ar Department of Heal Important: If Item 3 any Injury or other | 9000 | 4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lic | | Mou | 33 | | BREW MEMO | | | ME, INC | C. |
| Physicia | | 23a. Part1. Entar the disaasa, or co shock, or heart feilure. List on | mplications that day one cause on a | caused the daa eech line. | Do not ent | er the moda of | ROLL STREE dying, such as cardi | | | Ap | Deproximate terval Between inset and Death |
| /Medica | al | Immediate Cause (Fine) diseasa or condition resulting in death) | . Sta | phyloute k | COCA | e sep. | 815 | | | a | 10 days |
| '60, be executed sician and burial-transit | Examiner | Sequentially list conditions, | b. Au | | REMUL or es a conseq | | lure | | | - | Sday |
| S sta de | dicai | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last | C | Due to (c | or as a conseq | uenca of): | | | | | |
| Box 6 leath certific attending p | cian/ | | d | | | | | | 11-0-1 | | |
| P.O. nat the d by the detached | by Physician/Me | Part II. Other significant conditions Corpray f | 4 | eath but not res | | | given In Part I. | | Yes 2□ No | ntribute to th | e cause of death? |
| of Vital Records, Physician: The law requires the certificate has been signed rail director, page 2 should be considered. | Completed b | Diabetes N | helli+ | ris | | | | | s an autopsy ormed? | availa | autopsy findings ble prior to letion of cause ith? |
| | | Mitral Va 25. Was case referred to medical | due | Replu | nem | ent | Of Place of D | 1 and a second | Yes 206 | 1 🗆 Y | BS 2000 |
| of Vita Physician: this certific | To Be | exeminer? | | - | ER/Outpatien | | Other: 4 Nursing | Homa 5 ☐ Res | | er (Specify) | |
| On Jing After fune | ation: | 27. Manner of Deeth 1 Naturel 5 ☐ Pending 2 ☐ Accident Investigati | | of Injury hth, Dey Year) | 28b. Time of Injury | | njury at Work? 1 □ Yes 2 □ No | 28d. Describe | how Injury occur | red | |
| Division To the Hospital or Attending within 24 hours after death To the Funeral Director. After completely filled in by the fune | Certification: | 3 ☐ Suicide 6 ☐ Could not determine | d Zee. Place | a of Injury - At hing, etc. (Specif | ome, farm, str | eet, factory, off | ice | 28f. Location City or To | (Street end Numi wn, State) | per or Rural Re | oute Number, |
| DIVI To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by | edicai | 29e. Certifying F (Check only one) Certifying F 2 Medical Ext | aminer: On the b | best of my kno esis of examine ener stated. | ewledge, deeth | occurred at the restigetion, in n | e time, date and place ny opinion, deeth occ | ce, and due to the curred et the time | cause(s) end made, dete and place, | anner as state and due to the | d. e ceuse(s) |
| To the To the Common | × | 29b. Signature and title of cartifier • Getmeeth | wfms | 1- Ho | usest | USF AC | ense number 240232/ | -GC9915 | 29d. Date signed | stan | 1997 |
| - 5 | | 30. Name and address of person who | 4 PWD | se of deeth (Item 240 | n 23a) (Type, | Belver Belver | dere to | e Bal | to, UI | 212 | 215 |
| | tate | 31/Date filed-(Month, Day, Year) | | Registrar's Signa | | | | | | | |

Records, of Vital Division

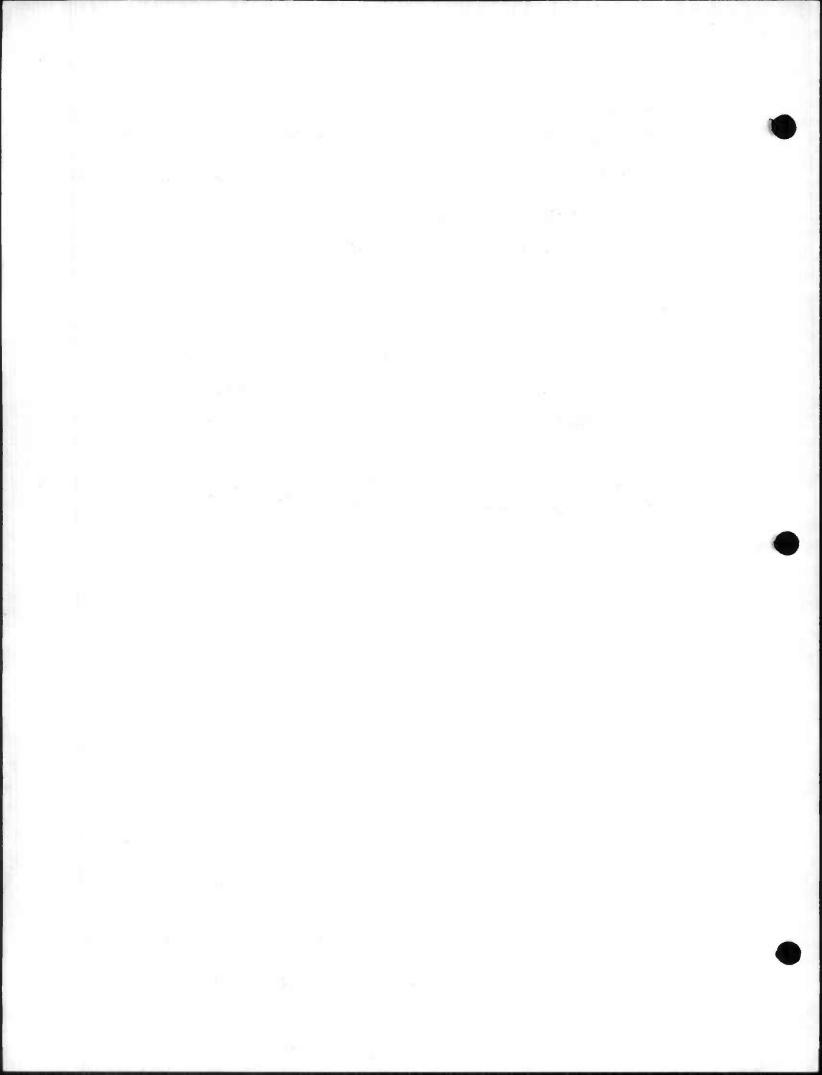
> 31. Date filed (Month, Day, Yeer) SEP 0 8 1997 State Registrar

111 Penn Street, Baltimore, Maryland 21201

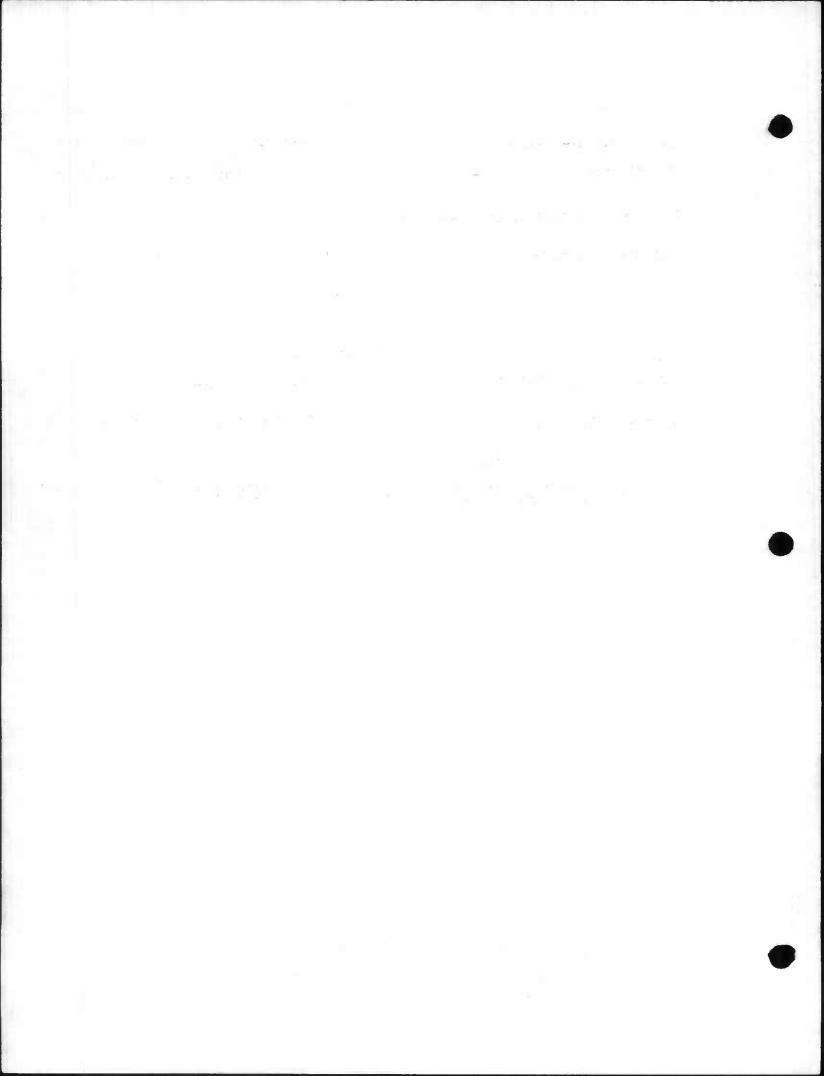
30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

O.C.M.E

AUG. 28, 1997



| | | | Sta ITEM:8 perFH G-751 9-10-97 | te of Marylan eoh | | riment of t | | | giene 9 | 1 4 | 1302 |
|------------|--|---------------------|---|--|------------------------|--|---|--|--------------------------|-------------------------------------|--------------------------------|
| | Physici /Medi | | 1. Decedent's Nama (First, Middla, Last) Gerard | | G | atling | | 2. Data of Dec Month Augus + | | Year 1997 | Time of Death |
| | Examir | | 4e. Facility Nama (If not Institution, giva street a | nd number) | | | 4b. City, Town, or L | | 4c. County | of Death | |
| | | | Joseph Ritchie Hospi | | | | Baltimore | | | imore (| City |
| | Funeral Director | P | 5. Social Security Number 6. Sex 154 M 20 | 7. Aga (In yrs. I | ast birthday) Yrs. | Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birt (Month, Day March | h y, Year) 12, 195 | 9. Birthpleca Country) 0 Mary | (Steta or Foreign |
| | pus * | | Usual Rasidance of Decedent 10a. Steta 10b. County | 10c City | , Town or Loc | eation | | | 11 | 104 | Insida City Limits |
| | Marylan f ahow | 5 | Maryland Baltimore C | | imore | | | | | | 1 Yas 2 No |
| | 28a | rect | 10e. Street and Number | | | 10f. Zip Coda | | and the same of th | 10g. Citizen of | | |
| | 3a or | D | 828 North Eutaw Stree | et | | 21201 | | | U.S.A. | , | |
| | filed within 72 hours after death with the Manyland Hyglana. dher than "naturel", or Rems 23a or 23a-1 show ent, the Medical Examiner must be recitled at | by Funeral Director | 11. Marital Status 12. Was | Decedant Evar in U.sed Forcas? | S. 13. W | | Hispanic Origin? (Sp en, Maxican, Puarto | | | ce - American I ck, Whita, atc. | ndien, |
| 21215-0020 | hours af turel', or al Exam | d by | 3 ☐ Widowed 4 ☑ Divorced Yas | as, Giva ror Datas: | | ☐ Yas 2ဩNo | | 1 | Specif | | |
| 5 | in 72 | Completed | 15. Decedant's Education (Specify only highast grade compl | | (Giva k | ant's Usual Occup iind of work done O NOT usa ratire | pation during most of work d) | ring | 160. Kind of B | usinass/Indust | ry |
| 212 | a with plana. | шо | Elementary/Secondary (0-12) Coil 12 | ega (1-4or 5+) | | mputer A | | | Comput | er | |
| | offie offie vent, | Be C | 17. Fathar's Nama (First, Middla, Last) | · · · · · · · · · · · · · · · · · · · | | | 18. Mothar's Nem | a (First, Middla, | Maidan Suman | na) | |
| yla | 2 should be filed with and Mental Hygiana. Is marked other than aumatic avent, the M | To | George Gatling | | | | Dorothy | Johnson | | | |
| Maryland | 2 sh and is m | | 19a. Informant's Name/Ralationship (Type, Prin | t) | | | and Number or Rui | | | | |
| | 1 and Health em 27 | | Gerard Gatling, Jr. 20a. Method of Disposition | 20h PI | | ye Islan | nd Court, | Annapo | | | |
| Baltimore, | Pages nent of int: If it | | 1 □ Burial 2 □ Cramation 3 □ Removel 4 □ Donation 5 ᡚ Othar (Specify) in | from Stata | emetery, crem | atory or othar pla | | 410 | | - City or Town, | |
| Ball | permit. Pag Department Important: It eny Injury o | | 21. Signature of Fur)erai Sarvice Licansaa Ronald S | Wade Direc | ctor S | Nema and Address State Ana Saltimore | ass of Facility atomy Boar e, Marylan | rd, 655 | W. Bal | timore | Street |
| | | | 23a. Part1. Enter tha disease, or complications shock, or heart failura. List only one cause | that causad the death | | | | | | App | proximate arval Batween |
| | Physician /Medical Examiner | | Immediate Course /Final | chcepho | 1000 | athy | | | | | sat and Death |
| | | P. | in actify | O () Pue to (or | as a consequ | ience of): | nic | | | - | namu |
| | licate be axecuted physician and s the burial-transit | Examiner | b | PIUL, (| as a consequ | to a contract of the | TIID | | - | > Un | Known |
| ó | an an rial-tr | Exa | Sequentially list conditions, if any, laading to immediata cause. Entar Undarrying Causa (Disaase or injury c | 000 10 (01 | as a consequ | rance orj. | | | | 1 | |
| 58760, | cata be axecuted physician and tha burial-transit | dicai | Causa (Disaase or Injury that Initiated evants rasulting in death) Last | Dua to (or | as a consequ | anca of): | | | | | |
| _ | a as t | | | | | | | | | - | |
| Box | auth certif attending for usa a | ian | d | | | | | | | | |
| 0 | requires that the death certifi seen signed by the attending hould be detached for use as | Physician/M | Perl II. Other significant conditions contributing | to death but not rasu | iting in tha un | darlying cause gh | ven in Pert I. | 23b. Did t | obacco uss co | ntributs to the | causs of death? |
| 0 | es that the de igned by the be detached | | TDY | | | | | 101 | Yea 2 No | 3 Probabl | y 40 Unknown |
| Records, | uires nid be | d by | 11000 | | | | | 24a. Was | an autonsv | 24b. Wara s | utopsy findings |
| 00 | w requir been s should | Completed | Fremia | | | | | | med? | | ole prior to etion of cause |
| Re | The iaw ata has b page 2 s | omp | HepC | | | | | 101 | as 2 No | 1 □ Ya | |
| Vital | | BeC | 25. Was casa rafarred to medical | | | | 26. Place of Deal | | - Comment | 1210 | / |
| of V | 0 0 2 | To | examinar? 1 Yas 2 No Hospital: | 1 Inpatiant 2 I | ER/Outpatient | 3□ DOA Ott | nar: 4 Nursing Ho | ome 5 Rasid | iance 8 Oth | nar (Specify) | Hospice |
| | | | 27. Mannar of Death 28a. 1 □ Natural 5 □ Panding | Data of Injury (Month, Day Year) | 28b. Tima of Injury | 28c. Inju | | 28d. Describe h | now injury occur | red | |
| sio | Attending ir death. ector: Aftai by the fune | cati | 2 Accident Invastigation | District the second | | | Yas 2 □ No | 201 1 11 10 | | 5 15 | |
| Division | or Attandi aftar death Director: A d in by tha f | Certification: | detarmined 288. | Place of Injury - At hor building, atc. (Specify) | | at, factory, offica | | 28f. Location (S City or Tow | | oer or Hurai Ho | uta <i>Number</i> , |
| | To the Hospital or I within 24 hours after To the Funeral Director Completely filled in E | | 29a. Cartifiar 12 Certifying Phyalcian: 1 | o tha best of my know | rledge, deeth | occurred at tha tir | ma, data and piaca, | and dua to tha | cause(s) and m | anner as stated | 1. |
| | n 24 n 24 he Fu | edicai | (Uneck only 2 Medical Examiner; On | tha basis of axaminati mannar stated. | on and/or Inva | astigation, in my o | pinion, death occur | red at the time, o | date and place, | and dua to tha | cause(s) |
| | To the within 2 To the compla | × | 29b. Signatura and titla of certifiar | ^ | | 29c. Licens | sa number | 2 | 29d. Data signe | Month, Day, | Year) |
| | | | Katharinetta | Vruon | MD | . D3 | 75712 | 2 | 8/18/ | 197 | |
| | | | 30. Name and eddrass of person who completed JOSE Ph (LICH EY | causa of death (Item | 23a) (Type, P | Beeth | niove. | 2120, | / | | |
| | Sta | te ar | 31. Date (illed (Month, Day Year) | 32 SE201223 STORE | Hares. | | | | | | |



21215-0020

Baltimore, Maryland

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

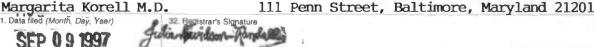
Certificate of Death

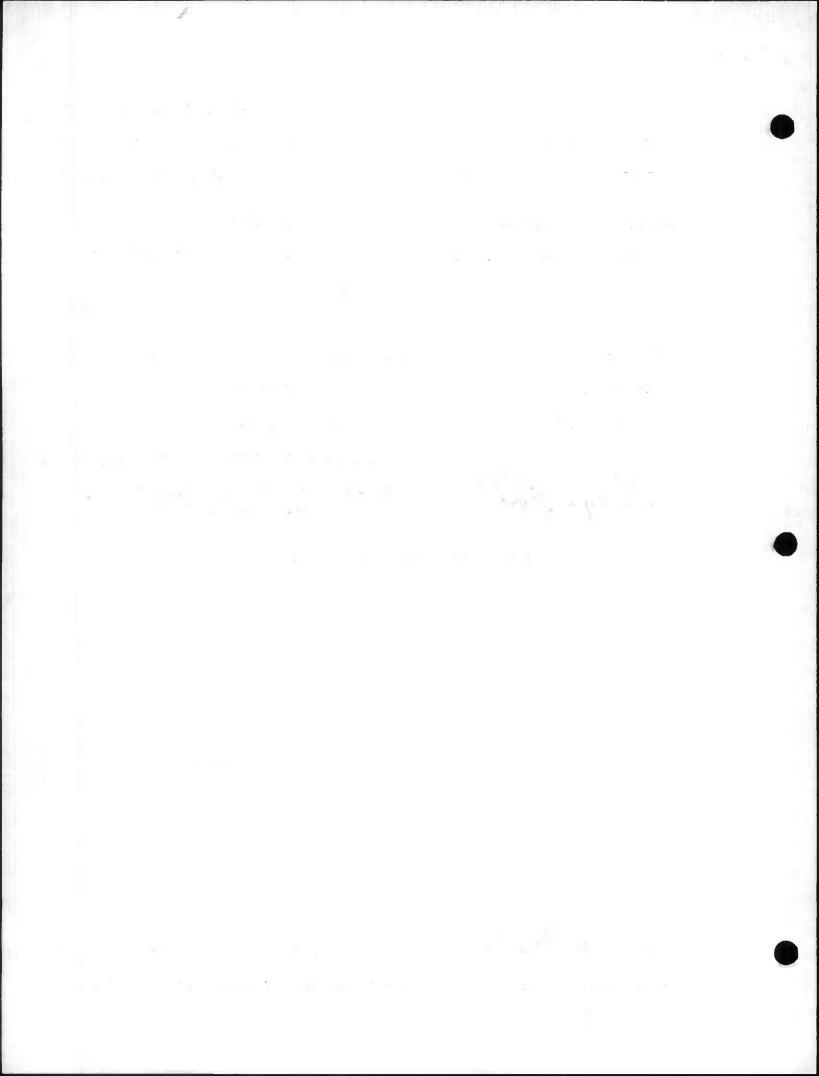
The lew requires that the death certificate be executed -tran and Box 68760, P.O. Records, director, page 2 should this certificate has Vital Attending Physician: of funeral After Division death. after death in by the

1. Decedant's Nama (First, Middle, Lest) 2. Data of Deeth 3. Time of Daeth Reba Elma Hampton Day **Physician** Month SEPTEMBER 04, 1997 1545PM /Medical 4e. Facility Nema (If not institution, give streat and number) 4b. City, Town, or Location of Daath 4c. County of Deeth Examiner 202 MIDLASS DRIVE APT.2D MIDDLE RIVER BALTIMORE COUNTY 5. Social Sacurity Number If Undar 1 Yeer If Undar 24 Hrs. Hours Min. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Dey, Yaar) Birthplace (State or Foreign Country) **Funeral** Months Days 1□ M 2**∑** F 69 227-34-4001 Director Yrs. June 7, 1928 Virginia Usual Rasidance of Decadant death with the Maryland 10a Stata 10h County 10c. City, Town or Location 10d. Insida City Limits 28a-f show a or 28a-f sh 1 Yas 2 No Director Middle River Maryland Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? a 23a 202 Midlass Drive Apt. 2 D 21220 United States Funeral Hems 12. Was Dacedant Evar in U,S Armed Forcas? Was Dacedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puerto Ricen, atc.) 14. Race - American Indien, Black, White, atc. the Medical Examiner filed within 72 hours efter 1 ☐ Yas 2 😿 No If Yes, Giva Yaar or Datas: 1 ☐ Navar Married 2 ☐ Married 6 1 ☐ Yas 2 ☐ No Specify: þ Specify. 3X Widowad 4 ☐ Divorced "natural". White Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Dacedant's Education 16b. Kind of Businass/Industry (Specify only highast greda complated) than Elamantary/Secondary (0-12) College (1-4or 5+) Hygiene. 9 Years Seamstress Manufacturing h end Mental Hygi 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Meidan Sumama) Be Peges 1 end 2 should be Eddie Parks Mary Carter 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Straat and Number or Rurel Routa Number, City or Town, State, Zip Code) nt of Health e: If item 27 is Shirley Parks/Daughter 305 Maple Avenue Essex, Maryland 21221 of Disposition (Nama of Dispositi other 20b. Pleca of Disposition (Nama of camatery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 XBurial 2 Cramation 3 Ramoval from Stata 6 Depertment of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 9/8/1997 Baltimore, Maryland 21. Signatura of Fynaral Sarvica Licensaa 22. Nama and Addrass of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. 23a. Parl 1. Enter tha ding an or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fair and a comblication and the cause on each line. Approximate Intarval Batwaan Onset and Death **Physician** immediate Causa (Final Arteriosclerotic Cardiovascular Disease disaase or condition rasulting in daath) Examiner Due to (or es a consequence of) Examiner Saquentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceusa (Disease or Injury that Initieted events resulting in death) Last Dua to (or as e consequance of): Physician/Medical Due to (or as a consequanca of) Part II. Other significant conditions contributing to daeth but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ģ 24b. Were eutopsy findings evellabla prior to completion of causa of daath? Completed 24a. Was an autopsy performed? INSPECTION 1 ☐ Yes 2 ☐ No Be 25. Was casa raferred to medical 26. Place of Deeth (Check only ona) Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify, P 1 X Yas 2 □ No 1 ☐ Inpatiant 2 ☐ ER/Outpetlent 3 ☐ DOA Certification: 27. Mannar of Death 28a. Data of injury (Month, Day Yaar) 28b. Tima of 28c. injury et Work? 28d. Dascribe how Injury occurred 5 Panding 1 Natural 1 Yes 2 No invastigation 2 Accidant 3 Suicida 6 Could not be detarmined 28e. Plece of Injury - At home, farm, straat, factory, office building, atc. (Spacify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida To the Hospital o within 24 hours af To the Funeral D 1 Cartifying Physician: To tha best of my knowledge, deeth occurred et the time, dete and place, end due to tha causa(s) end manner as steted.

2 Medical Examiner: On tha basis of examination end/or investigation, in my opinion, death occurred et tha tima, date end place, and dua to the ceuse(s) end mannar stated. Medical 29a. Certifier 29b. Signature and titla of certifiar 29c. Licansa number 29d. Date signad (Month, Day, Year) O.C.M.E. SEPTEMBER 05, 1997 30. Nema and addrass of person who completed causa of deeth (Item 23a) (Type, Print)

State Registrar 31. Data filed (Month, Day, Yaer) SEP 09 1997



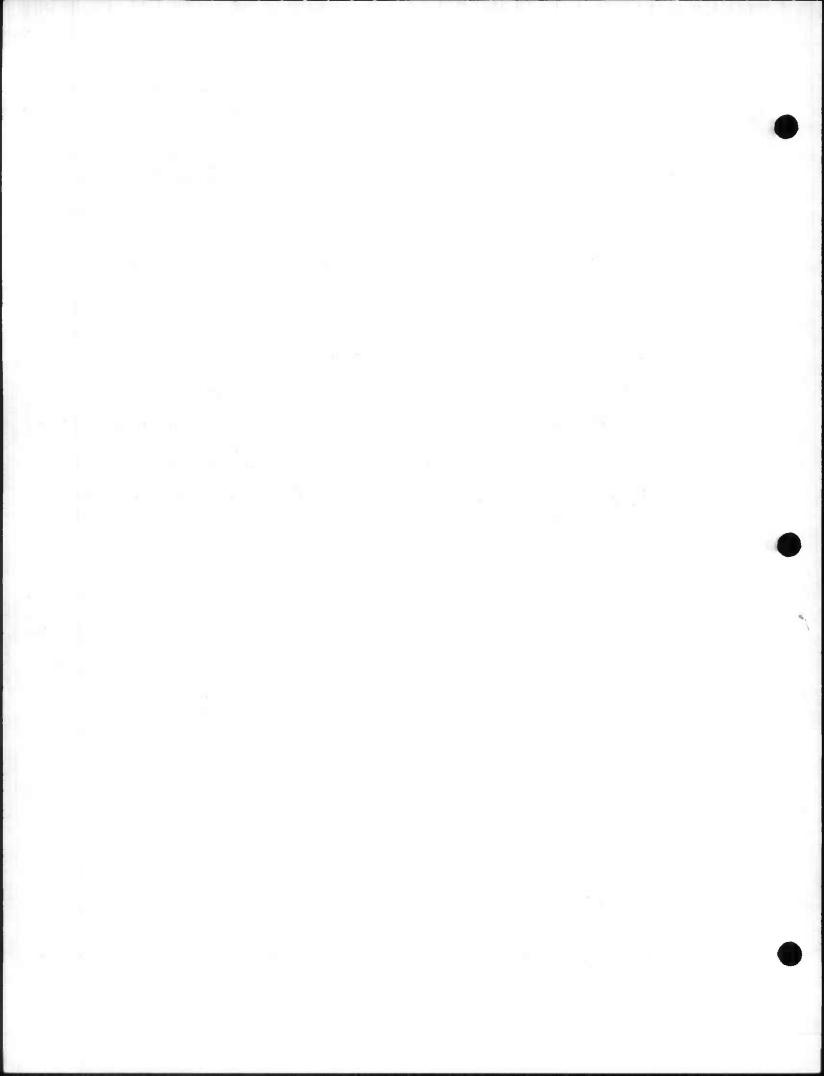


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

| | | | | State of Marylar | | rtificate of | | _ | Reg. No. | 7 2 | 7304 |
|-------------------------------|--|----------------|---|--|------------------------|------------------------------------|---|--------------------------------------|--------------------------------|-------------------------|---|
| | Physici | an | 1. Decedent's Nema (First, Middle, Last |) | | | | 2. Date of De Month | | Yeer | 3. Time of Deeth |
| | /Medi | | RUFUS | HI | PP | | | Septem | ber 4 1 | 997 | 5-AM |
| 1 | Examir | ier | 4a. Facility Name (If not institution, give Stella Maris | | | | 4b. City, Town, or L Timoniu | | | of Death timor | e Co. |
| | Funeral Director | | 230-03-4909 | x 7. Aga (In yrs. XM 2□F 80 | lest birthday) Yrs. | If Under 1 Yaar Months Deys | if Undar 24 Hrs. Hours Min. | 8. Data of Bir (Month, Da 03-1 | th ly, Year) 0-17 | 9. Birthpiad Country | ca (Stata or Foreign |
| | fand ow | | Usual Residence of Decedent 10e. Stete 10b. County | 10c. Ci | ty, Town or Lo | cation | | | | 10d | . Inside City Limits |
| | Mary a-f sh | tor | Md NA | Ва | ltimo | re | | | | | 1 ∑ Yas 2 □ No |
| | or 28 | Director | 10e. Street end Number | | | 10f. Zlp Code | | | 10g. Citizen of W | | 7 |
| | s 23e | erai | 1213 East Feder | ral Street 12. Was Decedant Evar in U | 16 40 1 | 21202 | Hannala Odalas (Ca | it. V N- | USA | - American | Indian |
| 020 | be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or flems 23a or 28a-f show event, the Medical Examiner must be notified at | by Funeral | 11. Marital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced | Armed Forces? 1 ☐ Yes 2 1 No If Yes, Giva Yeer or Detes: | | f Yes, specify Cub | Hispanic Origin? (Span, Mexican, Puarto Specify: | Rican, atc.) | | k, White, etc | o. |
| 2-0 | 72 hou | | 15. Decedent's Edu | cation | 16a. Deced | dent's Usuel Occup | pation | de a | 16b. Kind of Bu | | |
| 2121 | filed within 7 Hyglene. ther then "r ent, the Med | Completed | (Specify only highest grade Elementery/Secondery (0-12) Grade School | College (1-4or 5+) NA | | orer | during most of work d) | ang | Wareho | use (| Company |
| pur | be filed ntal Hygi d other event, II | Be | 17. Fathar's Nama (First, Middle, Last) Dave | Hipp | | | 18. Mother's Nem | | | ught | |
| IZ, | d 2 should be ith and Mental it? Its marked or treumatic eve | 7 | 19e. Informent's Neme/Reletionship (Ty | | 19h Mellin | Address (Street | and Number or Rui | | | | ode) |
| Ma | d to | | | rton, Jr. | | - | g Drive | | | | |
| altimore, Maryland 21215-0020 | T h | | 20e. Mathod of Disposition \$□\$Burial 2 □ Cramation 3 □ P 4 □ Donetion 5 □ Other (Specify) | Same val from Chats | cemetary, cren | stion (Name of matory or other ple | etery 09 | Dete 9-10-9 | 20c. Location - 7 Balt | | e, MD. |
| Balti | permit. Pa Departmen Important: any Injury once. | | 21. Signature of Funarel Sarvice License | | | . Neme end Addre | I | | | - | nd 21202 |
| | | | 23e. Pert1. Entar the disease, or complishock, or heart fellure. List only or | icetions that caused the deel | th. Do not ente | WM.C.MA er the mode of dyl | arch FH ng, such es cardiec | or respiretory a | E. Nort | A | enue pproximete iterval Between |
| | Physician /Medical Examiner | | Immediate Cause (Finel disease or condition resulting in death) | Prostate | Cano | 280 | | | | 0 | nset and Deeth |
| | | ner | | Due to (d | or es e conseq | juenca of): | | | | | |
| | ficate be executed physician and is the burial-transit | Examiner | Sequentially list conditions, | Due to (c | or as e conseq | uence of): | | | | | |
| 68760, | sician buria | | Sequentially ilst conditions, if any, leading to immadiate cause. Enter Underlying Cause (Diseasa or injury that initiated events |) | | | | | | 1 | |
| _ | | Medicai | resulting in deeth) Last | | r as e conseq | uence of): | | | | | |
| Box | that the deeth certified by the ettending detached for use a | Physician/M | | 1 | | | | | | 1 | |
| o. | he de / the e | ysic | Pert il. Other significant conditions con | tributing to death but not res | ulting in the ur | nderlying cause giv | ven in Pert I. | | | tribute to th | ne cause of death? |
| S, D | es that the igned by th be detach | by Pt | | | | | | 10 | Yss 2□ No | 3 Probab | bly 4 Unknown |
| Vital Records | been s | Completed b | | | | | | | an autopsy ormed? | avella | autopsy findings able prior to eletion of cause ath? |
| Ä | 0 - 6 | Com | | | | | | 10 | Yea 2000 | 1 🗆 Y | res 2 No |
| /ita | ysician: The serificate director, pag | Be | 25. Wes case referred to medical examiner? | i de la la la la la la la la la la la la la | | la: | 28. Place of Deel | h (Check only | one) | | |
| ō | 5 00 0 | ion: To | 27. Menner of Death | lospitel: 1 ☐ Inpatient 2 ☐ 28e. Dete of Injury (Month, Day Year) | 28b. Time of injury | 28c. Injui Wo | 4 LI Nursing Ho | | dence 8 20the | | HOSPICE |
| Division | or Attending after death. Director: After I in by the fune | Certification: | Accident Invastigetion Suicide Suicide Could not be determined | 28e. Plece of Injury - At h building, etc. (Specif | ome, ferm, stre | | 165 2010 | 28f. Location (City or To | Street end Numbe wn, Stete) | er or Aural A | loute Number, |
| | Hospita 24 hours Funeral stely filled | edical C | | sician: To the best of my knotes: On the basis of examine and menner steted. | | | | | | | |
| | To the fithin 2 To the comple | Me | 29b. Signeture and title of certifier | ~ ~ 1 | 29c Licens | se number | | 29d. Dete signed (Month, Day, Year) | | | |
| (|) | | 30. Name end eddress of person who co | | | | TTMONTHM | MD 214 | 103 | | |
| | Sta | te | 31. Dete flied (Month, Day, Year) | 32. Registrer's Signs | eture | LIL KU. | TIMONIUM, | FID ZI | 173 | | |
| | Registr | | SEP 0 9 1997 | Julia Varidson | Pands 00. | | | | | | |

State of Maryland / Department of Health and Mental Hygiene

| ### Funeral Director Social Security Number 10 | Dey Yeer BER9 1.997 4c. County of Deeth | ime of Deeth J. > 30 a.m |
|--|---|-----------------------------|
| A Facility Neme (If not institution, give street end number) 4a Facility Neme (If not institution, give street end number) 907 KENT AVENUE BAI,TIMORE | 4c. County of Deeth | J⇒30am |
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| end manner stated. 29c. License number | d. Dete signed (Month, Dey, Yo | 8er) |
| | | |
| 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) | entout - 9 | FPPI |
| Bevery Drucker The Johns Hoskins Hospital B | eptember 9 | FPP1, |
| State 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture | eptember 9 | FPPI, |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) SEP 06,1997 Dorothy S. Hocheder 5:30 AM 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth 1901 Stringtown Road Sparks Baltimore | Honder 1 Year | Honder 24 Hrs. | 8. Dete of Birth | Months | Days | Hours | Min. | MAX | 14, 1919 9. Birthplaca (Stete or Foreign Country) Maryland 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 1□ M 21 XF 78 Yrs 213-12-0574 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Baltimore Sparks 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 1901 Stringtown Road 21152 USA 12. Wes Decedant Evar in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 14. Rece - Amarican Indian, Bleck, White, etc. 1 ☐ Navar Married 2 ☐ Married 1 ☐ Yes 2 ☑ No if Yes, Giva Yeer or Detes: 1 ☐ Yes 2X No Specify. Specify: 3 ☑ Widowed 4 □ Divorced White 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker Domestic 18. Mothar's Neme (First, Middla, Melden Surneme) 17. Fether's Neme (First, Middle, Last) William Schlesinger Elsa Boehm 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) John B. Hocheder/son 1813 Stringtown Road Sparks, MD 21152 20b. Plece of Disposition (Neme of cemetary, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☑ Cremetlon 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory, Inc. 09/06/97 Baltimore, MD 21. Signeture of Funeral Service Licensage

Dawn F. McDonald

Dawn F. McDonald 22. Nama and Address of Fecility Cremation Society of Maryland, 299 Frederick Road Baltimore, MD 21228 23e. Pert1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on aech line. Approximete Intervel Between Onsat end Deeth Immediate Ceuse (Fine) unknown diseesa or condition resulting in deeth) Due to (or es e consequence of): Due to (or es e consequanca of): Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 NUnknown none

/Medical

Physician

/Medical

Examiner

Director

Funeral

þ

10e. State

Funeral

Director

tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinat must be nothing at

e filed within 72 hours efter el Hygiene. other than "natural", or ite

permit. Pages 1 and 2 should be f Depertment of Health and Mentel I Important: If item 27 is marked of any injury or other traumatic eve

Baltimore, Maryland 21215-0020

P.O. Box 68760

Records,

Division of Vital

the Marylend

with

death

Physician Examiner physicien end s the burial-transit

been signed by should be detac

certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completaly filled in by the funeral director, I

Examine Physician/Medical þ Completed 27. Medical Certification:

25. Wes case referred to medical

29e. Certifier

31. Dete filed (Month, Pay, Yeer)

9 199

Sequantially list conditions, if any, leeding to immadiate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in deeth) Lest

24e. Wes en eutopsy performed?

24b. Were autopsy findings evaileble prior to completion of causa of deeth?

1□ Yes 2No

1 ☐ Yes 2 ☐ No

26. Piece of Deeth (Check only one)

| 1 Yas 2 | lo | 1 ☐ Inpatient 2 ☐ | ER/Outpatient | 3□ € | OA VINE 4 Nursin | g Home 5 Residence 6 ☐ Other (Specify) |
|------------------------------------|---------------------------|---|------------------------|----------|---------------------------------|---|
| Menner of Death Neturel Accident | 5 Pending investigation | | 28b. Time of Injury | М | 28c. Injury at Work? 1 Yes 2 No | 28d. Describe how injury occurred |
| 3 ☐ Sulcide 4 ☐ Homicide | 6 Could not be determined | 28e. Piece of Injury - At h building, etc. (Specia | ome, farm, stree | t, fecto | ory, office | 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) |

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) determined 4 Homicide

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner es steted.

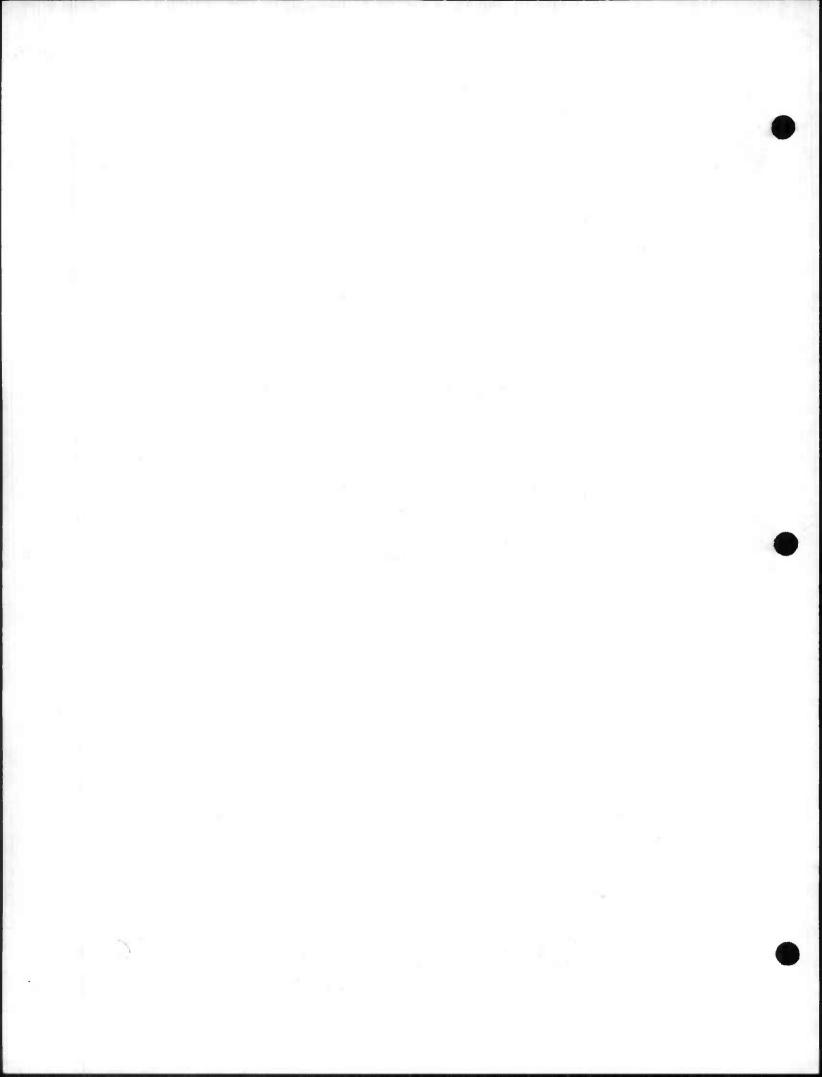
2 Madicat Examiner: On the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and my more stated. 29b. Signature and title of dertifie 29c. Licansa numbar

29d. Date signed (Month, Dey, Year)

MAMO 30. Neme end eddress of person MEGOR

Jappa Rd #103, Bathmore, MD 21234 30. Registrar's Signature

State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Tima of Death 1130 **Physician** Spember Month /Medical 4a. Fecility Nemedif not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Baltino Baltinore Baltinou lchust 5. Social Security Number If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 11/14/1911 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Deys 1**∑** M 2□ F 85 Yrs 241-14-6572 Director North Carolina Usual Residence of Decedent the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f shov traumatic avent, the Modical Experient must be notified at 1 ☐ Yes 2 No Directo Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 578 6th Street 21122 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Orlgin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 Naver Married 2 Married 1 ☐ Yas 2 ☑ No If Yes, Give X Yeer or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No by 3 Widowed 4 Divorced Specify: American Indian Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry tel Hygiene. Elamantary/Secondary (0-12) College (1-4or 5+) Factory Meat Packing 7th permit. Pages 1 and 2 should be file Department of Health and Mentel Hy, Important: if item 27 is marked othe any injury or other traumatic avent, once. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meidan Sumame) Be Clayton Hunt Mary Jacobs 19e. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Clark Oxendine / Son 578 6th Street Pasadena, Maryland 21122 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete Burial 2 Cremation 3 Removal from State
4 Donation 5 Othar (Specify) Garden of Faith Cemetery 9/9/97 Baltimore, Maryland Sonature of Funeral Service bio 22. Name end Address of Fecility 23e. Pert1. Enter the disease for complications that caused the death. Do not antar the mode of dying, such as cerdiec or respiratory errest,

Approximate

Approximate

Approximate David J. Weber Funeral Home Approximate Interval Batwaan Onset and Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner Examiner physician and the burial-transit be executed Sequantially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest Dua to (or es e consequence of): Box 68760 Physician/Medical Due to (or es e consequence of) 88 9SD Por Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Records, P.O. the 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveileble prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? peen pege 2 or Vital

or rospital or Attending Physician: Th

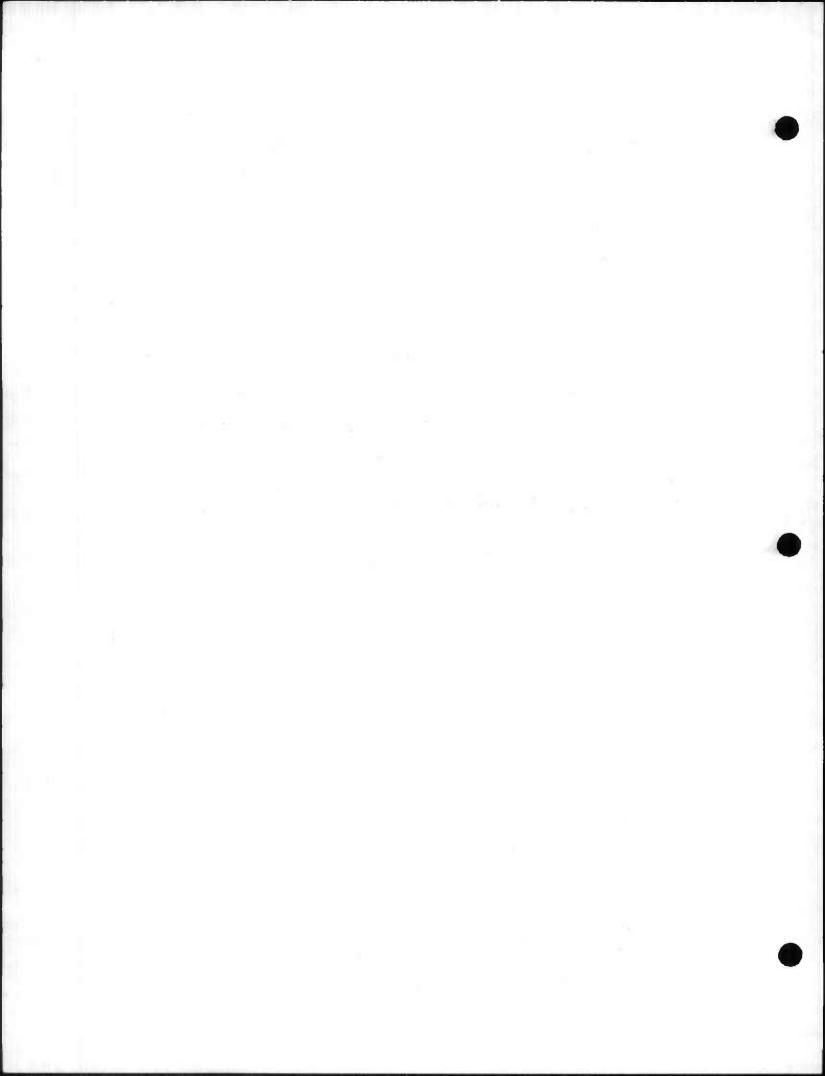
in 24 hours after deeth.

he Funeral Director: After this comidetely filled in hor the 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Wes cesa rafarrad to medicel exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Rother (Specify) Hospitel: 1 | Inpatiant 2 | ER/Outpetient 3 | DOA 1 Yes 2 No Certification: To 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation Naturel 2 Accident 1 ☐ Yes 2 ☐ No Vone 6 Could not be detarmined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 | Homicide 29e. Certifier Medical 🔀 Csrtifying Phyeician: To the best of my knowledge, daath occurrad at tha time, date end plece, end due to the ceuse(s) end menner as steted. pletely (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. the within To the 1) (Type, Print) N. Charles St. Balto. Md 2120x 30. Name and address of person who complated caysa of death (Itam 23a) (Type, Print)

State Registrar A. Riles

SEP 0 9 1997

31. Data filed (Month, Day, Year)



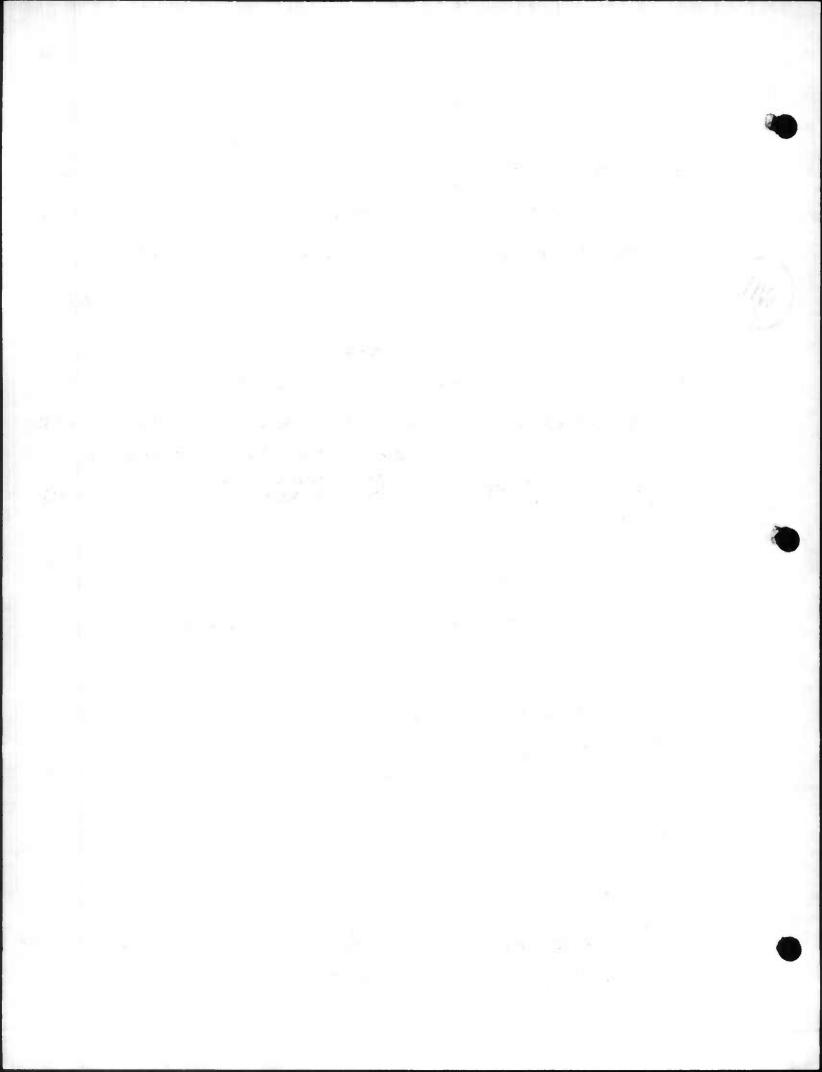
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Deeth **Physician** Hirshfield Month Sylvia 1545 September 3 1997 /Medicai 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Johns Hopkins Hospital BALTIMORE 7. Aga (In yrs. last birthday) If Under 1 Yaar | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Securily Number 9. Birthplaca (Stata or Foreign **Funerai** 1□ M 200 F Days Yrs. 212-01-3082 79 Director August 30 1918 MARYLAND Usual Rasidance of Decadent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show BALTIMORE BALTIMORE 1 Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? ò 130 SLADE AVE., APT. 523 21208 USA 12. Was Decedant Evar In U,S. Armed Forces? 14. Race - Amarican Indian, Black, Whita, atc. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1 Never Merried 2 Marriad 1 ☐ Yas 2 ☐ No If Yas, Giva X Yaar or Datas: 1□ Yes 2□ No 3 ☐ Widowed 4 ☐ Divorced WHITE Be Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 15. Decadant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry 2121 Elemantary/Secondary (0-12) Collega (1-4or 5+) HOMEMAKER OWN HOME altimore, Maryland 17. Fether's Nema (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Surname) 2 should be 1 and Mental h DAVID HORNSTEIN SOPHIE **HERTZBACH** Pages 1 and 2 should 19a. Informant's Name/Raletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Department of Health at Important: If item 27 is any injury or other trau WILLIAM HIRSHFIELD (HUS.) 130 SLADE AVE., APT. 523 BALTO., MD 21208 20a, Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other placa) 20c. Location - City or Town, Stata 1X Burial 2 Cramation 3 Ramoval from State HEBREW YOUNG MEN 9/8/97 BALTIMORE, MD 4 ☐ Donetion 5 ☐ Othar (Specify) ture of Funaral Sarvice License 22 Name and Address of Eastlity BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 RUTT 234. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, allows, or relate failure. List only one cause on each line. **Physician** /Medical Immediata Ceusa (Final Respiratory Failure disaasa or condition resulting in death) Examiner Physician/Medical Examiner Sepsis Sequentially list conditions, if any, laading to Immediata causa. Enter Underlying Cause (Disaesa or Injury that initiated events rasulting In death) Lest Myelodysplastic Syndrome
Due to (or as a consequence of): P.O. Box 68760. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Heart Failure Records, þ 24b. Ware autopsy findings available prior to completion of cause of death? Be Completed 24e. Wes en eutopsy ombocytopenia Insut 1 Yas 2 No 1 ☐ Yas 2 ☐ No of Vital or Attending Physician: 25. Was case rafarrad to medical 26. Place of Deeth (Check only ona) Hospitel: 1 Sinpatient 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yas 2 No 27. Mennar of Death 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred After Division Natural 5 Panding Invastigation death. 1 TYas 2 No 2 Accidant within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not ba determined 3 Sulcida 28e. Place of Injury - At home, ferm, straat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide 1 Cartifying Physician: To the best of my knowladge, deeth occurred et tha tima, data and placa, and dua to tha ceuse(s) and mannar as stated.

2 Madical Examinar: On the basis of axamination and/or invastigelion, in my opinion, death occurred at the time, date and placa, and dua to the causa(s) and manner stated. Medical (Check only one) the 29b. Signatura and litle of cartifian 29c. License numbar 29d. Dete signed (Month, Day, Year) will Brohmer, MO September 5 1997 30. Name end eddrass of person who completed causa of daath (Item 23e) (Type, Print) Julie R Brahmer, MD Johns Hopkins Hospital 32 Registrar's Signatura 31. Data filad (Month, Day, Yaar) State Lulia Davidson-Randall SEP 0 9 1997

DHMH 16 Rev 6/95

Registrar



| BALTIMORE, MARYLAND 2121 | - nours after death. Page 6 may be retained by the hospital or atte | filled in by the funeral director, page 5 should be detached for use on, or removal. | he medical examiner must be notified at once. |
|--|---|---|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 68760, | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a rouns after death. Page 6 may be retained by the hospital or after | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

Pages 1, 2, 3 should

| | 1 - FOR STATE REGISTRAR | STATE OF MARYLA | AND / DEPART | | | | YGIENE EG. NO. | | | |
|--|---|--|---|---|---|----------------------------|--|-----------------------------------|---|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | HOL | TZ MA/ | | JEAN. | 2. DATE OF I | DEATH DAY | YEAR | 3. TIME OF DEATH | |
| | | 1 🗌 M 2 🔀 F | 91 YRS. | F UNDER 1 YEAR ONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. R LOCATION OF D | 7. DATE OF E (Month, De | BIRTN y, Year) 15, 1905 | e. BIRTNI Country Po1 | PLACE (State or Foreign and | |
| CTOR | Hebrew Home Of Gre | | | Rockvi | | EATN | | ntgom | | |
| COMPECTOR | Maryland Montgo | omery | | ckville | 2 | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 \(\square\) NO | |
| KUNEBAL | 6121 Montrose Road | 12. WAS DECEDENT EVER IN | U.S. ARMED | 13. WAS DEC | ZIP CODE 20852 ENDENT OF NISPAI | NIC ORIGIN? (S | Decify Yea or No | S.A. | HAT COUNTRY? American Indian, | |
| B | 1 Never Married 2 Married 32 Wildowed 4 Divorced 15. DECEDENT'S EDUCAT | FORCES? 1 YES | TES T | 1 TYES | 2 NO Specifi | γ. | | Black, White, atc. Specify: White | | |
| COMPLETED | (Specify only highest grade con | College (1-4 or 5 +) | 16a. DECEDENT'S US (Give kind of wor life. Do NOT use i Beautici | k done during mo retired.) | N it of working | | o of Business/in | IDUSTRY | | |
| | 17. FATNER'S NAME (First, Middle, Last) | | | | | ME (First, Middle | s, Maiden Surname) | | | |
| TO BE | Wolf Landsman 190. INFORMANT'S NAME (Type/Print) Henrietta Berger Ruth Graizgrund 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State Zip Code) 4601 North Park Avenue, Apartment 817 Chevy Chase, Maryland 20815 | | | | | | | | | |
| | 20s. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Remove 4 Donation 5 Other (Specify) | al from State 20b. | PLACE AND DATE OF 1'ES Provided Come | DISPOSITION (Na If ac Column terv | maryrand nbia9/03 | /1997 | 20c. LOCATION - | - City or Tow | - A [+ 3-4. | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN Donald C. | ISEE | nyez_ | STETN | D ADDRESS OF FA | CILITY MEMODITA | L FUNER | AL HO | ME, INC. | |
| | 23. PART I. Enter the diseeses, or con ehock, or heert fellure. Lis | inbucations that caused | tipy death. Do not | enter the mo | de of dying, suc | h as cardiac | or respiratory a | rreat, | Approximate Interval Between Onset and Death | |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) | Colon DUE TO (OR AS A | Colon Cancer DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| TION | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | | |
| CERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST d | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | | |
| ¥ | PART II. Other algnificant conditions of | contributing to deeth bu | it not resulting in | the underlying | ceuse given in | | . WAS AN AUTOPSY PERFORMED? YES 2 NO | | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| PHYSICIAN: MEDIC | DID TOBACCO USE CONTRIE | | | | UNCERTAII | N D | | | 1 YES 2 NO | |
| SICI/ | | 1OSPITAL: Inpatient 2 ER/Outpe | s. PLACE OF DEATN | THER: | 5 🗆 Residence | 6 Other (So | ec(fy) | | | |
| ВУ РНУ | 27. MANNER OF DEATH 1. Natural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Morith, Day, Year) | 28b. TIME (| OF 28c. INJ | JRY AT | | BE HOW INJURY OF | CCURED | | |
| 28a DI ACE DE IN HIDV At home to the state of the state o | | | | | | | | or or Rural Ro | oute Number, | |
| COMPLETED | 29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. | | | | | | | | and manner sa stated. | |
| TO BE | 29b. SIGNATURE AND TITLE OF CERTIFIER | uD | | | 29c. LICENSE NUI D378 | ABER | 29d. DA | TE SIGNED | MONTH, Day, Year) ABER 1, 1997 | |
| | A RAJVANSHI M.D | 121 Cones | TH (ITEM 27) (Type, Pr | P Ln# | 409 R | Lockwi | Ue m | 0 20 | 852_ | |
| 31. DATE FILED (Month, Day, Year) SEP 0 9 1997 Julia Davidson-Render | | | | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene 0.7

| | | | | | | , , , , , , , | | | | Death | | Reg. No. | 3 1 | 2/3/0 |
|------------|--|--------------------|--|------------------------|--|-----------------------------------|-----------------------------|------------------------------|-----------------|---|----------------------------------|----------------------------------|--|--|
| | Physic /Medi | | 11-11-11- | cK | | | | | | | 2. Dete of De Month Sep+ | Dey | Yaer 1997 | 3. Time of Death 12: 40 PM |
| 9 | Exami | ner | 4e. Facility Neme (If not institu Good Samar | | | | | | | 4b. City, Town, or L Balti | | 4c. Cour | ty of Deeth | |
| | Funeral Director | | 5. Social Security Number 217–22–9341 | 6. Sex 1 ☐ M | 7. / | Aga (In yrs. las | st birthday) Yrs. | if Under 1 Months | 1 Yaar Deys | if Undar 24 Hrs. | | | 9. Birthp | place (State or Foreign htry) |
| | and w | | Usuel Residence of Decedent 10a. Stete 10b. Cou | | | 10c. City, | Town or Lo | cation | | | | | | 10d. Inside City Limits |
| | the Marylar 28a-f show notified at | ctor | Md. B | altimo | ce | | Ba | altimo | ore | | | | | 1 ☐ Yas 2 📉 No |
| | 23e or 28 ust be no | ral Director | 10e. Street end Number 932 Quantr | il Way | | | - | 10f. Zip (| | 21205 | | - | tizen of What Country? USA | |
| 0200 | Examiner.m | d by Funeral | 11. Maritel Stetus 1 □ Naver Married 2 □ N 3 ☑ Widowed 4 □ Divor | larried ' | Wes Daceder Armed Forca: I ☐ Yes 2☐ If Yas, Giva Yeer or Detas | XNo. | | | | Hispenic Origin? (Sp an, Mexican, Puerto Specify: | pecify Yes or No Rican, atc.) | Spec | aca - Americ ack, White, ity: Wh | |
| M | P | Completed | (Specify only hig | | on m <i>pleted)</i> | | 16e. Decad | lent's Usuei | Occup k dona | petion during most of world) | king | 16b. Kind of | Business/In | dustry |
| 212 | | omo | Elementary/Secondary (0-1: 12th | 2) (| Collage (1-4o | r 5+) | | Vaitre | | a) | | Re | staur | ant |
| pu | al Hy t other | Be C | 17. Fether's Nama (First, Midd | | | | | | | 18. Mothar's Nam | | | ime) | |
| Maryland | Sould I Ment Marked Marked | To | J0sep | | | | | | | | lie D. | | | |
| Mai | d 2 sh th and 7 is re traum | | 19e. Informant's Neme/Relation | | | wht or | | | | end Number or Ru | | | | |
| re, | f Health fem 27 other t | | Peggy Anna 20e. Method of Disposition | Patriug | je/ daug | | | sition (Neminetory or other | | re Lane | Baltimo | 20c. Location | | |
| omi | Page Sent of Int: If I | | 1 ☐ Burial 2 ☐ Cremetic 4 ☐ Donation 5 ☐ Other | | vel from Stat | e Oak | LAwr | i Ceme | eter | cy 9/10 | 0/97 | Balti | more | MD. |
| Baltimore, | permit. Pa Departmen Important: any injury once. | | 21. Signeture of Funerel Servi | | 1 | . 01. | <i>a</i> 0 | connel | l1v | ss of Fecility Funeral | Home of | Essex | | |
| | | | 23e. Pert1. Enter the diseasa shock, or heart feilure. L | or complication | ons thet caus | ed the deeth | 20 Act entr | QQ Ma | G Gyi | ng, such as cardiac | timpre, 1 | 1d. 212 | 21 | Approximete intervel Batwaen |
| 1 | Physician (Markins) | | | - 1 | | | * | | | | | | | Onset end Deeth |
| 1 | /Medical Examiner | | Immediete Ceuse (Final disease or condition rasulting in deeth) | e | | COPI | | | | | | | | > loyrs > 20yrs |
| Ш | | Jer | | | | Smole | | uence of): | | | | | } | > 2 0 1/05 |
| Box 68760, | death certificate be executed e ettending physician and of for use as the buriel-transit | n/Medical Examiner | Sequentielly list conditions, if any, leeding to immadiate cause. Enter Undarlying Causa (Disease or Injury that Initieled avants resulting in daeth) Lest | c | | Dua to (or e | s e conseq | | | | | | | 7 20 Y IS |
| 4 | e deatl | Physician/M | Part II. Other significant cond | itions contribu | iting to death | but not resulti | ng in the ur | nderlying ca | usa gi | ven in Pert f. | 23b. Did 1 | obacco use o | ontribute to | the cause of death? |
| P.0 | that the ed by th detech | Phy | End Stage | Reno | e D | isease | | | | | 10 | 708 2□ No | 3 Pro | bably 4 Unknown |
| Records, | v requires that the de been signed by the should be deteched | Completed by | Hypertensio. Probable | n | | | | | | | | en eutopsy med? | av | ara autopsy findings eileble prior to |
| Rec | has has | mple | Multifocal | | | - / | 1. | | | | | 1/ | of | mpletion of causa death? |
| | ilcian: The la certificate ha rector, page | | 25. Wes case refarred to med | | ~ (- | achyce | xraic | ~ | | 00 Pl / P | 101 | | 1[| Yes 20 No |
| of Vital | Physician: 'r this certifica | To Be | exeminar? | Hosp | ital: 1 Inpa | tient 2□FF | 3/Outpetien | 3 DOA | Ott | 26. Plece of Dae | th (Check only o | | ther (Specif | (v) |
| ion of | ling After fune | | 27. Manner of Death 1 Neturel 5 Pen | ding stigation | Ba. Date of in (Month, L | | 3b. Time of Injury | | c. Inju | | 28d. Dascribe I | | | <i>V</i> |
| Division | al or Atte s efter de il Directo ed in by th | Certification: | 3 ☐ Suicide 6 ☐ Coudate 4 ☐ Homicide | ld not be irminad 2 | Se. Pleca of I building, | njury - At home etc. (Specify) | e, ferm, stre | eet, fectory, | office | | 28f. Location (S City or Tox | | ber or Rura | al Route Number, |
| | To the Hospital or Attend within 24 hours effer deeth To the Funeral Director: completely filled in by the | edical | 29a. Certifier 1 Certification (Check only one) | ai Examiner: | n: To the bes On the basis end manner | of examination | edge, deeth n end/or Inv | occurred el estigetion, i | t the tie | ma, date and plece, opinion, deeth occur | end due to the red et the time, | ceuse(s) and r deta end place | nannar as s , and due to | tated. the ceuse(s) |
| | with To th | Σ | 29b. Signatura and titla of cert | fiar | 1 | | | 29c. | Licans | sa number | | 29d. Data sigr | | |
| | ^ | | Hyun | 7 /1 | m | _ / | nD |] |) 4 | 46907 | | Sep | + = | 7 /997 |
| | 3 | | 30. Nema and andress of pers | (| | 1./ | - 41 / | Print) | D | ltimore | 110 | | 0:- | 20 |
| | Sta | te | 31. Dete filed (Month, Dey, Ye | s alma | | trar's Signetur | | - | Da | ITIMOTE | (Lain | | 41 | 57 |
| | Registr | | SEP 0 9 1 | 397 | gillia | Davidson | -Randa | 202. | | | | | | |

area of overtal and and

| | | | State of M | larylar | nd / Departm <i>Certific</i> | | Health and Death | | V | 97 | 27311 |
|--|---|--|--|-----------------------------|--|-----------------------------|--|---|-----------------------------------|-------------------------------|---|
| ALL L | Decedent's Nama (First, | Middla, Last, |) | | | | <i>D</i> 0 a | 2. Data of De | Reg. No. | | 3. Tima of Death |
| hysician | Neil | R | ру | HERS | HMAN | | | Monih | Day ber 3,1 | Yaar QQ7 | 8:30 P.M |
| /Medical Examiner | 4a. Facility Nama (If not ins | | - | | III IIIII | | 4b. City, Town, or | | | y of Death | 0.30 F.F |
| | Franklin So | quare l | Hospital | Cent | er | | Rosedale | | Balt | imore | |
| uneral | 5. Social Security Number | 6. Sa: | 7. A | ga (In yrs. | last birthday) If U | hdar 1 Yaa | | | | | placa (Stata or Foreign |
| rector | 236-44-5896 | , | ≹M 2□ F | 6 | 5 Yrs. | | , Trouis Mini. | June16 | ,1932 | Mary | land |
| or Items 23a or 28a-f show uniner must be notified at Funeral Director | Usual Rasidance of Dacad 10a. Stata 10b. C | | ore | 10c. Cit | ty, Town or Location | Ess | ex | | | 1 | 10d. Inslda City Limits |
| be notified be notified Director | 10e. Street and Number | | | | 10f | Zip Coda | | | 10g. Citizan of | Whai Cour | ntry? |
| E 2 | 1510 De | nton F | Road | | | | 21221 | | US | A | |
| Funeral | 11. Maritai Status | | Was Decedani Armed Forcas | ? | ,S. 13. Was D | ecedant of specify Cul | Hispanic Origin? (S ban, Maxican, Puan | Specify Yas or No to Rican, atc.) | 14. Ra Bia | ce - Amaric | |
| 1 0 | | rorced | 1 X Yas 2 ☐ If Yes, Give Yaar or Datas: | | | s 2 X 0No | | | Speci | y: Wh | ite |
| lete | 15. De (Specify only | cedant's Edu highast grade | | | 16a. Decedent's I | work done | a during most of wo | rking | 16b. Kind of E | Business/In- | dustry |
| Completed | Elemantary/Secondary (07th |)-12) | Collaga (1-4or | 5+) | Self-e | | • | | Цоэт | U Eco- | ipment |
| | 17. Fathar's Nama (First, M | iddla, Last) | | | DETI- | ziilb TO | | ma (First, Middla, | | | 1pment |
| To Be | Everett | Hershn | nan | | | | | | Johnson | | |
| 1 | | ationship (Ty | pe, Print) | | 19b. Mailing Add | rass (Strae | | | | , Stata, Zip | Code) |
| 200 | 19a. informant's Name/Ralationship (Type, Print) Georgia Hershman/wife 19b. Mailing Addrass (Straat and Number or Rurel Routa Number, City or Town, State, 1510 Denton Road Baltimore Md. 21221 | | | | | | | | | | |
| or othe | 20a. Mathod of Disposition | | | | Place of Disposition | Nema of | ace) | Data | 20c. Location | ocation - City or Town, Stata | |
| 17 00 | 1 Donation 5 ☐ Ot | | amoval from State | | ak LAwn Ce | | | 7 | Balt: | imore | Md. |
| 를 함 | 21. Signatura of Funaral Sa | arvica Licansa | aa 🦳 | (2) | / | | rass of Facility 1y Funera | | | | |
| cian dical diner | 23a. Pan'i. Entar the disea shock, or heart failure immediate Ceusa (Final disease or condition rasulting in death) | LIBLORY OF | Cardiog | genic | 7 | | ring, such as cardiad | c or raspiratory a | rrast, | | Approximata intarvai Batwaan Onsai and Death |
| nin an | | _ B | Acute m | yoca: | rdial infa | arcti | on | | | | 3 days |
| iclan/Medical Examiner | Sequantially list conditions if any, laading to immadiat cause. Enter Underlying Causa (Disaase or Injury thet initiated evants rasulting in daath) Last | { | i | | or as a consequance | | | | | | |
| hed for | Part ii. Other eignificant co | nditions con | tributing to death I | out not res | ulting in the underlyi | ng causa g | ivan in Part i. | 23b. Did 1 | tobacco use co | ontribute to | the cause of death? |
| Ph | | | | | | | | 10 | Yee 2√2 No | 3 Prol | bebly 4 Unknow |
| page 2 should be o | | | | | | | | | an autopsy med? | av | ara autopsy findings aliable prior to mpiation of cause death? |
| rector, pag | | | | | | | | 101 | Yas 210 No | 10 | ☐ Yas 2☐ No |
| director. | 25. Was casa rafarred to m axaminar? | | ospital: | | | 0 | 26. Piaca of Deathar: | ath (Chack only o | ona) | | |
| D P | 1 ☐ Yes 2 🛣 No 27. Mannar of Death | 1. | 1 28a. Data of Inj | | ER/Outpatient 3 28b. Time of | DOA | 4 LI Nursing F | foma 5 Rasid | | | y) |
| ed in by the funera Certification: | 1 StNetural 5 F 2 Accident | ending nvestigation Could not be | (Month, De | ay Year) | Injury M | |]Yas 2□No | | | | |
| ed in by the | | etermined | 28a. Piace of in building, e | jury - At ho tc. (Specif | oma, farm, siraat, fac y) | otory, office | | 28f. Location (S City or Tov | | oer ör Rura | al Routa Number, |
| completely filled in by Medical Certifi | 29e. Cartifier 1 1 Ce (Check only 2 Me | rtifying Phya dicai Examir | ician: To the best er: On the besis of and manner si | of exemine | wledga, death occur tion and/or invastiga | red et the t tion, In my | ime, dete and place opinion, daath occu | a, and due to the urred et the time, | ceuse(s) and m deta end place, | ennar as si and dua to | ialad. o tha causa(s) |
| | 29b. Signatura and ditte of o | eritier | Jan. 11 | e- M | 10 | 29c. Licen | 15a number 140819 | 1 | 29d. Data signa Septem | 1 | Day, Year) |
| 10 | 30. Nama and addrass of p | erson who co | mplatad causa of | death (Iten | n 23e) (Type, Print) | 4 | , , , , , | | - FICIN | V-C! ~ | 1111 |

State Registrar

SEP 0 9 1997

Dr. Marco Zamora 31. Data filad (Month, Dey, Year)

32. Registrar's Signatura July Davidson Randello

9000 Franklin Square Dr. Baltimore, Maryland 21237

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First Middle Lest) 2. Data of Daath 3. Tima of Death Month Yaar **Physician** Howard, Jr. AUGUST 21, 1997 8:53 PM. /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Deafh Examiner 2000 ODELL AVE APT. #1610 BALTIMORE If Under 24 Hrs. 8. D 5. Social Sacurity Number If Undar 1 Yaar 6 Sax 7. Aga (In yrs. last birthday) Birthpleca (Stata or Foraign Country) 8. Data of Birth (Month, Day, Year) **Funeral** 1₩ M 2□ F Months Days Houra Min 226-22-2052 73 Yra. Director May 10, 1924 North Carolina Usual Rasidance of Dacadant the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits show "naturel", or items 23s or 28s-f show edical Examiner must be notified at Maryland Baltimore City Baltimore 1 ☐ Yas 2 ☑ No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mantai Hygiena. I be man 21 is marked other than "naturel", or items 23a or 2 any injury or other traumstic event. 2000 Odell Avenue unknown U.S.A. Funeral 12. Was Decedant Evar in U,S Armad Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Raca - Amarlcan Indian, Black, Whita, atc. 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 ☐ Navar Marriad 2X Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 🖾 No Spacify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Private 10 Laborer 17. Father's Nama (First, Middla, Last) 18. Mother'a Name (First, Middla, Maidan Sumama) Phil Alston Emma Jane Wade 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Ruth Neville/daughter 7985 Aududon Avenue, Baltimore, Maryland 21204 20b. Placa of Disposition (Nema of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Buriai 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 N Donation 5 ☐ Other (Specify) 21. Signature Fundal Sarvice Licensaa Wade, Director 22 Name and Addrass of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, Mryland 21201 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hook, or heart feilure. List only one cause on each line. Approximata fntervel Betw Onsat and Death **Physician** fmmediata Cause (Finel diaeasa or condition rasulting in death) /Medical a Arteriosclerotic Cardiovascular Disease Examiner Due to (or es e consequence of) Examiner the death certificate be axecuted physician end the burial-transit Sequantially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disaasa or injury that initiated evants resulting in death) Last Dua to (or aa a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Dua to (or as a consequence of): use as I ò Part fl. Other algnificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown MELLITUS ρ 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Waa an autopsy performed? Completed page 2 INSPECTION 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yas XX No or Attending Physician: director 25. Was case refarred to madical Be 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 X Rasidance 6 Othar (Specify) XYaa 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Data of Injury (Month, Dey Year) 27. Mannar of Daath 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred After 5 Panding 1XXVatural after deeth. Director: Aft 1 ☐ Yas 2 ☐ No invastigation 2 Accident 6 Could not ba 3 Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Pleca of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 ☐ Homicida 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to the cause(s) and mannar es stated.

**Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Cartifian Medical (Check only one) within 2 the 29b. Signatura and titla of certifian 29c. Licansa number 29d. Data signed (Month, Day, Year) 0 O.C.M.E. AUGUST 22, 1997

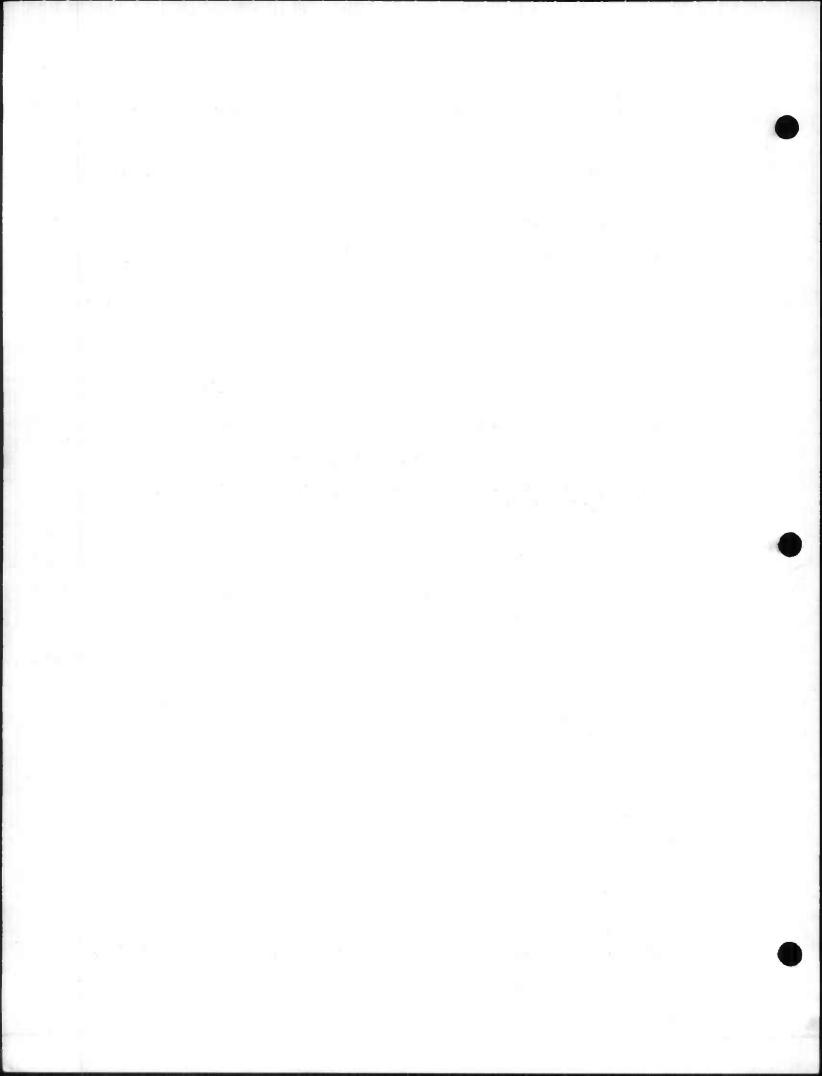
State Registrar 30. Nama and addresa of person who complated causa of death (Itam 23a) (Type, Print) Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201 white Desires 60 Handelle

DHMH 16 Rav 6/95

State of Maryland / Department of Health and Mental Hygiene

| | | | | | Cer | tificate of | Death | | Reg. No. | 1 | 21313 |
|---|---------------------|------------------|---|--|------------------------|--------------------------------------|---|---------------------------------|-------------------------------|----------------|---|
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| | ysicia Vedica | _ | LILLIAN | C. INGL | E | | | SEPT | 04 | 97 | 625AM |
| | amine | | 4a. Fecility Nema (If not Institution, | 0 | | | 4b. City, Town, or Lo | | h 4c. County | of Death | |
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| Fun Dire | | | 5. Social Sacurity Number 2203046/5 Usual Rasidance of Dacedant | 1 M 2 F 63 | last birthday) Yrs. | Months Days | | 8. Daia of Bir | th ly, Year) 21,1934 | 9. Birth | pleca (Stata or Foraig ntry) ern, MD |
| hend we | 11 | ŀ | 10a. Stata 10b. County | 10c. City | , Town or Loc | eation | | | | Ţ. | 10d. Insida City Limits |
| e Mary | Milled | ctor | MD Anne A | rundel Se | vern | | | | | | 1 Yas X No |
| ith th | 9 P | Oire | 10e. Street and Number | | | 10f. Zip Coda | | | 10g. Citizen of | What Cour | ntry? |
| 23a | 1 | ra E | 8160 North R | oad | | 21144 | 4 | | U.S. | Α. | |
| er de | Die. | Funeral Director | 11. Maritai Sieius | 12. Wes Decedant Ever in U, Armed Forcas? | | as Decedani of I Yas, specify Cub | Hispanic Origin? (Speen, Maxican, Puarto | ecify Yes or No Rican, etc.) | | ce - Americ | can Indien, atc. |
| A 14.13-004.0 d within 72 hours efter death with the Marylend giene. rr than "naturel", or flems 23a or 28a-f show | Exami | þ | 1 Naver Married 2 Married 3 Widowed 4 Divorced | d 1 ☐ Yas 2 XNo If Yas, Giva Yaar or Dates: | 1 | ☐ Yas 2 ∑ No | Specify: | | Specif | y: Whi | ite |
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| within 72 ene. than na | 3 | Completed | Elemantary/Secondary (0-12) | College (1-4or 5+) | | | od) | | | | |
| | f. | | 17. Fathar's Nema (First, Middle, La | ct) | HOM | emaker | 18. Mothar's Name | a /First Middle | Own H | and the second | |
| d is b | | o Be | Charles G. War | | | | Hilda | | | Ta) | |
| 2 should and Men | the I | ပ | 19e. Informent's Name/Reletionship | | 19b. Mailine | Address (Street | and Number or Run | | | Stata Zit | n Code) |
| and 2 salth ar | other traumatic | | Richard Ingle | Sr./Husband | 1 | 0 North | | Severn | | 2114 | |
| s 1 and f Health Itam 27 | | ŀ | 20a. Mathod of Disposition | 20b. P | iaca of Dispos | ition (Name of atory or other pla | 1 | Data | 20c. Location | - | |
| Peges nent of int: if it | ury or | | 1 ☑ Buriai 2 ☐ Cramation 3 4 ☐ Donation 5 ☐ Othar (Spec | Hemoval from Stata | | | palCem. | 9/8/97 | Odent | on. | MD |
| permit. Peges 1 and Department of Health Important: If Itam 27 | any injury once. | | 21. Signatura of Ponerai Service Lic | | | | Funeral Y Avenue | | | | |
| | | | 23a. Part1. Eniar tha disease, or co shock, or heart feiture. List on | implications that caused the death | | | | | | , | Approximate |
| Physic | ian | 1 | SHOCK, OF HEART TERIORE. LIST OF | ly one couse on aach ina. | | | | | | | Intarvel Batwean Onsat and Death |
| /Medi | _ | | Immediate Cause (Final disaasa or condition | CARDIAC | A 2 2 1= | ST | | | | | 30 MIN |
| Exami | | | resulting in daath) | a. | as a consequ | | | | | 1 | SO MIN |
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| ifficate be exe | et s | Medical | rasulting in daath) Last | · · | as a consequ | | | | | | 0. |
| 0 0 | or use a | 2 | | a ADENOCALC | NORA | 570 | MACH | | | | 3 MONTH |
| death ce | d for | Physician/ | Part II. Other significant conditions | contributing to death but not resu | Iting In the un | darlying causa gi | ven in Part I | 23h Did | tobacco usa co | ntribute t | o the cause of deeth |
| it the de | tache | <u></u> | | - | in the one | aanjing oodsa ga | on ar arc. | 1 🗆 | N | | bably 4 Unknow |
| es that | 8 | 2 | 1416MYOCTTONIC | MA | | | | | | | |
| ne law requires that the death | should | Completed | RENA FAILU | ne | | | | | an autopsy rmed? | ev. | era autopsy findings vailabla prior to emplation of causa daath? |
| The le | page | E | | | | | | 10 | Yas 2 No | 1[| ☐ Yas 2☐ No |
| sician: The | 8 | | 25. Was cesa referred to medical | | | | 26. Placa of Daati | | | | |
| . 5. 00 1 | ē | 0 | axaminar? 1 ☐ Yas 2 ☐ do | Hospitel: 10 Appatiant 2 1 | ER/Outpatient | 3□ DOA Oth | | | | ar (Specif | <i>(y)</i> |
| ding Ph h. After th | | | 27. Mannar of Death Naturel 5 ☐ Pending | 28a. Date of Injury (Month, Day Year) | 28b. Tima of Injury | 28c. Inju | ry at | 28d. Dascribe | how injury occur | red | |
| Attending ir death. | Ted I | Cati | 2 Accidant invastigati | be | | | Yes 2□No | | | | |
| or Attanding efter death. Director: After | 6 | Certification: | 4 Homicida determina | 28a. Plece of Injury - At ho building, atc. (Specify | me, ferm, stra | at, factory, office | | 28f. Location (City or To | Straat and Numb vn, State) | er or Rura | al Route Number, |
| pital ours erai | Dell | | 29e. Cartifier Certifying F | Physician. To the best of mulinous | deader deadh | | 4-4 4-4 | | | | |
| the Hospital or nin 24 hours effe the Funeral Dir | etery | edica | (Check only one) | Phyaician: To the bast of my known minar: On the basis of axamination and manner stated. | on end/or inve | astigation, in my o | ma, data and piece, opinion, death occurr | ed at tha ilme, | date end place, | end dua to | teted. o tha causa(s) |
| To the Hospital or vithin 24 hours effer To the Funeral Dire | dwo | | 29b. Signature and sittle of certifier | | | 29c. Licans | sa number | | 29d. Dete signe | d (Month, | Day, Year) |
| 1 | | | MUEL O | Q un | | 5. | 1,671 | | a_ v | 10- | 7 |
| V | | 1 | 30. Nama and address of person wh | o compiated ceusa of deeth (Itam | 23e) (Type, P | rint) | 17/4 | | 7-7 | -1_ | / |
| | | | WF SINDEL | | | | Bor | IMM | SMD | 21 | 239 |
| | State | 9 | 31. Data filad (Month, Day, Year) SEP 0 9 1997 | Sulla 30 FER WELL S PROM | | | 0 | | | | |
| Reg | gistra | r | 2FL 0 8 1331 | 0 | | | | | | | |

DHMH 16 Rev 6/95



| | 4 Danishant No | (- \ A) | | | Certif | ficate | of L | Death | | | | . No. | | | |
|--------------------------------------|--|--|--|--|--|--|------------------------|---|---------------------------------|--------------------------------|--|---------------------------------|---|--|--|
| n | Decedent's Name (First, Middle, I | | | | | | | | | 2. Date of Month | | Day | Year | | ime of Death |
| al | HARRY L. JON 4e. Fecility Name (If not institution, g | | umbarl | | | | | h City To | wn orlo | 09 ocation of D | | 05 -1 4c. County | | | :00 AM |
| er | 550 EAST 38TH | | 100000 | | | | | BALT | | | eatti | , | / A | n | |
| _ | | . Sex | | yrs. last birtl | | f Under 1 | Year | If Under | 24 Hrs. | | Birth | | 9. Birth | nplace (S | State or Foreign |
| | 245-20-0301 | 1/20 M 2□ F | 72 | 2 Y | rs. Me | lonihs [| ays | Hours | Min. | 8. Dete of (Month) 12-1 | 2-1 | 1924 | N. | untry) | |
| | Usuai Residence of Decedent 10a. State 10b. County | | 100 | . City, Town | and analis | | | | | | | | | | |
| ດ້ | MD. N/A | | 100. | | | IMOR | 172 | | | | | | | | ide City Limits Yes 2□ No |
| Director | 10e. Street and Number | | | - D | | 10f. Zip Co | | | | | 100 | Citizen of l | Affrat Co. | | (100 223110 |
| | 550 EAST 38TH | CMDEE | m | | , | | 12 | 1 0 | | | 109 | USA | what Cot | untry? | |
| Funerai | 11. Marital Status | 12. Wes Dec | cedent Ever i | in U.S. | 13. Was | | | | ialn? (Sp | ecify Yes or | No- | | e - Amer | rican Indi | ian. |
| Ē | 1 Never Married 2 Married | Armed F | orces? 2 No live | | | | | n, Mexica | n, Puerto | Rican, eic. | es or No- eic.) 14. Race - Ame Black, White | | | | |
| þ | 3 ☐ Widowed 4 M Divorced | If Yes, G Year or I | live Dates: VV | WI | 10 | Yes 25 | No | Specify. | | | | Specify | y: B: | LACI | K |
| eted | 15. Decedent's (Specify only highest g | Education |) | 16a. I | Decedent' | 's Usual C | ocupa | ation | t of work | ina | 16 | b. Kind of B | usiness/li | ndustry | |
| Completed | Elementary/Secondary (0-12) | College (| (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) | | | | | | | 30115 | 0.5 | DD C | |
| | 17. Father's Name (First, Middle, Las | 5+ | | C | COLLEGE PROFFESOR | | | | | | | | | PRO! | FFESOR |
| Be | | t) | | | | | | | | | uie, Ma | iden Suman | ne) | | |
| 9 | UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town | | | | | | | | | | Cinto 7 | in Code | | | |
| | | KASEY JONES (DAUGHTER) 1324 SHERWOOD AVE. BALTO., MD. 21239. | | | | | | | | | | | | | |
| | 0a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State | | | | | | | | | | | | | | |
| | 1 ☐ Buriai 2 Cremation 3 ☐ Removel from State | | | | | | | | | | | | | | |
| L | 4 Donation 5 Other (Specify) GREEN MOUNT CREMATORY09/06/97 BALTO., MD. 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. | | | | | | | | | | | | | | |
| | 21. Signeture of Funeral Service Lice | ensee | | GREE | | | | | | Y09/0 | 06/9 | 97 BA | LTO | • , M | U • |
| | 21. Signeture of Funeral Service Lice | ensee | 114 | GREE | 22. Na HEN | ame and A | vddres W• | s of Facili | KINS | 5 & 5 | SONS | s co. | | | υ• |
| | 23a. Pert1. Enter the disease, or co | Mulications that | caused the d | | 22. Na HEN 490 | NRY | W. | JEN KRD | KINS | S & S | SONS MI | S CO. | | | |
| | William | Mulications that | caused the deach line. | | 22. Na HEN 490 | NRY | W. | JEN KRD | KINS | S & S | SONS MI | S CO. | | • Appro | eximate al Between and Death |
| | 23a. Pert1. Enter the disease, or co shock, or heart failure. List onl | mplications that ly one cause on | each line. | death. Do no | HEN 490 d enter th | NRY OS Y | W. ORI | JEN KRD | KINS | S & S | SONS MI | S CO. | | • Appro | ximate al Between |
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| to be completed by Physician/Medical | 23a. Part1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions 25. Was case referred to medical examiner? 15 Yes 2 No 27. Manner of Death | mplications ihat by one cause on a | Due to Due Due to Due to Due to Due to Due to Due D | death. Do not de | 22. Na HEN 490 on sequence on sequence the under the under | ame and ANRY 0.5 Y ne mode of tion nce of): ce of): ce of): | Address W • ORI | es of Facility JEN KRD g, such as | ty KINS Bit cardiac c | 23b. I 24a. V p | Did toba Yes Yas an a erformed Yes | CCO use co | 212 212 3 Pro 24b. V ecco | Appro- Intervious to the ca obably Vere autivaliable sompletion of death? Yes | eximate al Between and Death and Dea |
| to be completed by Physician/Medical | 23a. Pert1. Enter the disease, or co shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enier Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions 25. Was case referred to medical examiner? 15 Yes 2 No 27. Manner of Death 16 Natural 5 Pending investigating inves | mplications ihat by one cause on a. a. Try b. c. d. contributing to de a. Date (Monon on Inc.) | Due to Due Due to Due D | death. Do not de | 22. Na HEN 490 on sequence on sequence on sequence the under | ame and ANRY 0.5 Y ne mode of tion nce of): ce of): ce of): | Address W • ORI | es of Facility JEN KRD g, such as | KINS Bit cardiac of | 23b. I 24a. V p | Did toba Yes Yas an a erformed Yes | S CO. 21 | 212 212 3 Pro 24b. V ecco | Appro- Intervious to the ca obably Vere autivaliable sompletion of death? Yes | eximate al Between and Death and Dea |
| o be Completed by Physician/Medical | 23a. Pert1. Enter the disease, or co shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enier Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions 25. Was case referred to medical examiner? 10 Yes 2 No 27. Manner of Death 10 Natural 5 Pending | mplications ihat by one cause on a. a. Try b. c. d. contributing to de a. Date (Mornon be de 28e. Place) | Due to Due Due to Due D | death. Do not de | 22. Na HEN 490 on sequence on sequence the under the under | ame and ANRY D5 Y ne mode of ce of): ce of): dying caus All DOA 28c. | Other | es of Facility JEN KRD g, such as | KINS BA cardiac of | 23b. I 24a. V p | Old toba Vas an aerforme Yes Vay one) Lesidence be how | CCO use co 2 No autopsy d? 2 No | 212 ntribute 3 □ Pro 24b. V e c c o ner (Spec | Approintervionset to the ca obably Vere autivailable completion of death? Yes | eximate all Between and Death and Death and Death and Death and Death? Ause of death? Unknown oppy findings prior io an of cause 2 No |

29c. License number

039946

29d. Date signed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760, of Attending Physician: The law requires that the death certificate be ex

Baltimore, Maryland 21215-0020

128

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID EISENBERG M.D. 2400 KIRK AVE. BALTO., MD. 21218.

31. Date filed (Month, Day, Year)
SEP 0 9 1997

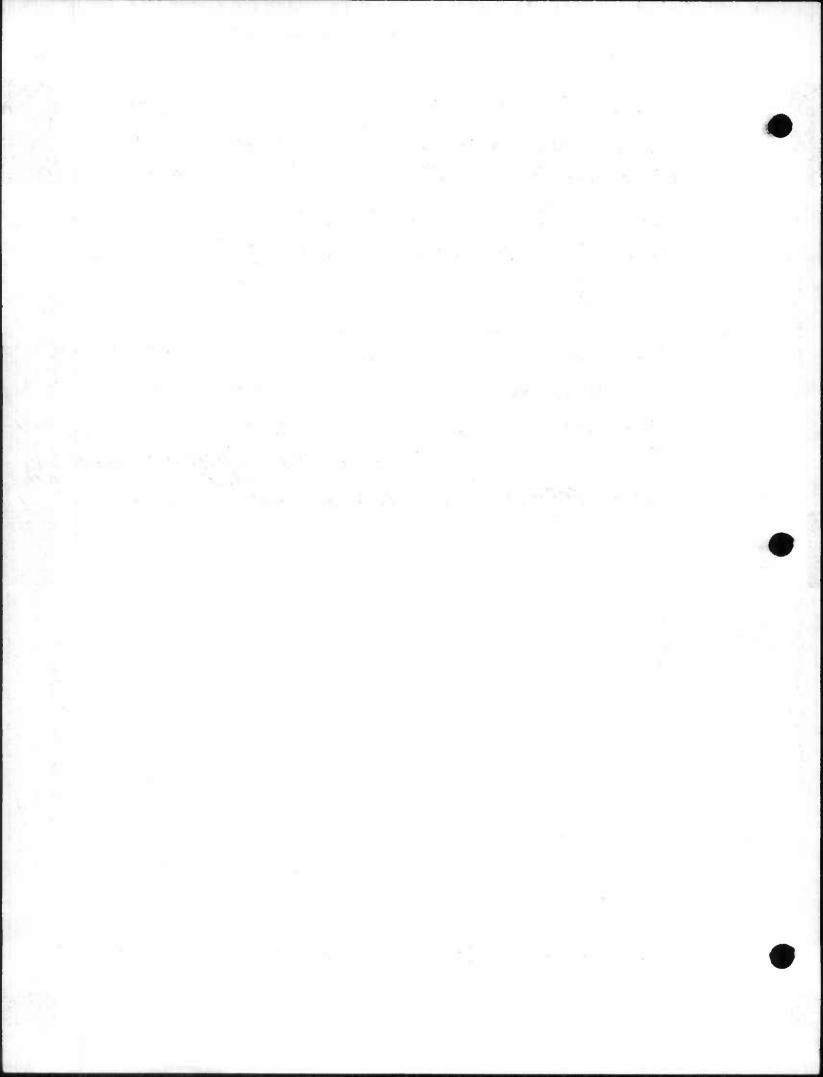
29b. Signeture and title of cartifier



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97

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|-----------|---|------------------|--|---|--------------------------|---|-------------------------------|---|----------------------------|----------------|---|
| | Physici | ian | 1. Decedant's Nama (First, Middla, Last | | | | | 2. Data of Dea Month | | Yeer 3 | . Time of Death |
| | /Medi | cal | LONNIE | JET | EX | | th City Town out | SEP. | 06.199 | 77 | 65m |
| J. | Examir | ner | 4e. Facility Nama (If not institution, giva | street and number) | 5/1/ | Home | 4b. City, Town, or Le | Cation of Death | 4c. County | A | |
| - | Funeral | | 5. Social Security Number 6, Sq | 7. Age (I | yrs. last birt | hday) If Under 1 Year | If Under 24 Hrs. | 8. Deta of Birth (Month, Day | V | 9. Birthpleca | (Stata or Foreign |
| | Director | | 215-12-0872 1 | M 2□ F | 80 | rs. Months Days | Hours Min. | 12/1 | 4/16 | Country) | MO |
| | /land | | Usuel Rasidanca of Dacedant 10a. Stete 10b. County | 10 | c. City, Town | or Location | | | • | 10d. | Inside City Limits |
| | ith the Marylar or 28a-f show | ctor | MD NI | 4 | 19 F | MIMOR | E | | | | 1 1 Yas 2 No |
| | 72 hours after death with the Maryland natural; or items 23s or 28s-f show dost Example must be notified at | Funeral Director | 10a. Street and Number | TIVENO | n- 1 | 10f. Zip Coda | 2125 | 1 | 0g. Citizan of V | Vhat Country? | |
| | ne 23e | erai | 2707 W. DC | 12 Was Decedant Eva | CID US | 13 Was Decedent of | Hispanic Origin? (Sp | ecify Yas or No- | 14 Bacı | e - American I | ndlan |
| 0 | after dea or items most m | Fun | 1 Never Married 2 Married | 12. Was Decedant Eva Armed Forces? 1 Yas 2 No | 111 0,0 | 13. Was Decedent of If Yas, specify Cub | | Rican, etc.) | Blac | k, Whita, atc. | |
| 215-0020 | *netural; or | d by | 3 ☐ Widowed 4 ☐ Divorced | If Yas, Give Yaar or Dates: | | 1 Yes 2 No | | | Specify | 011 | CK |
| 15- | n 72 h | lete | 15. Decedant's Edu (Specify only highast grad | | 16a. | Decedant's Usual Occu (Give kind of work dona lifa. DO NOT use ratire | pation during most of work | ing | 16b. Kind of Bu | , | |
| 212 | filed within Hygiene. Ither than o | Completed | Elamantary/Secondary (0-12) | Collega (1-4or 5+) | | LABOR | ER | | un | KNO | un |
| | tel Hygid d other event, | BeC | 17. Fathar's Nama (First, Middla, Last) | 1. / | | | 18. Mother's Nem | a (First, Middle, I | Maiden Suman | a) | |
| Maryland | 2 should be filed within end Mentel Hygiene. Is marked other than surmetic event, its M | 2 | UNKNOU | UN | | | UN | KNO | WN | | |
| Mai | | | 19a. Informant's Name/Ralationship (T) | pe, Print) | 196. | Mailing Addrass (Stree | t and Number or Run | A Routa Number | City or Town, | Stata, Zip Co. | de) 11\2/201 |
| re, | of Heelth Item 27 r other tr | | 20e. Method of Disposition | | 20b. Place of | Disposition (Nama of crematory or other pla | 27/1/2 | Data | 20c. Location - | City or Town, | Steta |
| mo | Pages nent of I int: If Its | | 1 Deurial 2 □ Cramation 3 □ F 4 □ Donation 5 □ Othar (Specify) | amoval from Stata | MI | YOU CEN | HETTERY | 9/9/97 | ANEV | WIN | E MA |
| Baltimore | permit. Page Department of Important: If any Injury or once. | | 21. Signatura of Funaral Service Licene | 16 | _ | 22. Nema and Addr | ass of Facility A | BORT | PWY | UE | FIA AT |
| _ | Z0 = 3 | | | 11/2 | | 638 N | GILMU | DR ST | BAC | 10 M | 021217 |
| | | | 23a. Fart1. Enter the disaasa, or compl shock, or haart failure. List only | cations thet causad the a cause on each line. | daath. Do n | ot antar the mode of dy | ing, such as cardiac | or raspiratory arr | est, | Ap Inti | proximata arval Batween set and Death |
| | Physician /Medical | | Immediate Causa (Final | Pela | 1.1. | - 100/ | nMie a | | | | - 6 00 |
| ľ | Examiner | | diseasa or condition rasulting in death) | Du | to (or as a | onsequenca of): | free | y | | | 1 |
| | be sit | nlnei | | Born | chiel | allere | me | | | 1 | ~ omo. |
| , | tificate be executed ig physician and as the buriel-transit | Examiner | Sequantially list conditions, if any, laeding to immadiata causa. Entar Underlying | Due | a to (or as a c | onsaquance of): | | | | 1 | |
| 68760, | ite be iysicia ne bur | Aedicai | Cause (Disaase or Injury that Initiated events rasuiting in death) Last | Due | to (or es a c | onsequance of): | | | _ | | |
| | The law requires that the death certificate be executed ate has been signed by the ettending physician and page 2 should be detached for use as the burle-Iransit | Med | Tasuling in datality East | | | | | | | | |
| Box | ettend for us | Physician/ | | | | | | | | | |
| P.O. | the de | hysi | Part II. Other significant conditions con | | ot rasuiting In | tha undarlying causa gi | ven in Part I. | | | | cause of death? |
| | ires that the death cer signed by the ettendin d be detached for use | by P | Degre dis | Indez | | | | 101 | es 2□ No | 3 Probabl | y 4 Dikilowii |
| Records, | v require been signal | | | | | | | 24a. Was a perfor | | avallat | autopsy findings bla prior to |
| 3ec | hes be | Completed | | | | | | | | of deat | ation of cause th? |
| | | | OF Management and the second | | | | | 1 U Y | | 1 □ Ya | is 2 No |
| of Vital | Physician: this certific ral director, | To Be | 25. Was casa rafarred to medical axaminar? | lospital: | 2□ ER/Out | patient 3 DOA OI | har: 4 M Nursing Ho | h <i>(Check</i> on <i>ly</i> or ma 5□ Raside | | ar (Snecifu) | |
| 100 | ding Phys h. After this funeral d | | 27. Manner of Death | 28a. Data of Injury (Month, Day Ye | 28b. T | | | 28d. Describe h | | | |
| Siol | Attending ir deeth. ector: After by the fune | catlc | 1 Natural 5 ☐ Panding 2 ☐ Accident invastigation 3 ☐ Suicide 6 ☐ Could not be | | | | Yas 2□No | | | | |
| Division | I or Attendia after deeth. Director: A in by the fu | Certification: | 4 Homicida datamined | 28a. Place of Injury building, atc. (5 | At homa, far Specify) | m, street, factory, office | | 28f. Location (Si City or Town | reet end Numb n, Stata) | er or Rural Ro | oute Number, |
| | spital hours neral y filled | | 29a. Certifiar 1 Certifying Phys | lclan: To the best of m | y knowledga, | death occurred at tha t | ima, date and place, | and dua to the c | ause(s) end ma | nnar as state | d. |
| | To the Hospital or Attending within 24 hours after deeth. To the Funeral Director: After completely filled in by the fune | edical | (Check only 2 Medical Exami: one) | ner: On the besis of axi and mannar stated | umination end | or investigation, in my | opinion, deeth occurr | red et the time, d | ete end plece, s | and due to the | cause(s) |
| | With To t | Σ | 29b. Signatura end titla of certifiar | | | | sa number | 2 | 9d. Date signed | (Month, Dey | (Year) |
| | \bigcirc | | Mejan | m | Occur - Te | 7 | 44817 | | sep. 0 | 1.17 | 17 |
| - | 0 | | 30. Nema and addrass of person who co | mpleted causa of daatt | (Itam 23a) (| Type, Print) Reliebeles | e come | Sal | hime | u, t | 4) 21215 |
| | Sta | | 31. Date filed (Month, Ray Licear) | 32/Hegistrar's | Signature | P | | 1 | | | |



| jhm | 1770 00 | | Please | Type or Pri | nt in B | lack In | delible | Ink | . Assur | e All Copie | s Ar | e Legible. | |
|--------------------------------|---|------------------|--|--|---|----------------------|-------------|--------|---------------|---------------------|---------------|-------------------|--|
| _ | LIAM T | HOI\ | 1AS | State of M | aryland | | | | | nd Mental H | lygie | ne 97 | .27316 |
| JEN | KINS Ite | ms: | 23a part I,II,27 per M | | 6/97 dh | _ Ce | rtificate | e of | Death | | Reg. | No. | |
| | Physici | an | Decedent's Neme (First, Middle, L. | | | | | | | 2. Data of Month | | Dev Year | 3. Time of Deeth |
| | /Medi | | William Thomas | | | | | | | AUGUS | | Dey 1997 Year | |
| آر ا | Examir | ner | 4e. Facility Neme (If not institution, gi | | | | | + | | , or Location of De | | 4c. County of De | |
| | | | 4111 HOLLINS PEF 5. Social Sacurity Number 6. | | | and the same | If Undar | 1 Vans | | more Cou | | | |
| | Funeral Director | | | 45 N 00 F | je (In yrs. le: 55 | St Dirthday) Yrs. | Months | Deys | | Min (Month. | Day, Ye | , 1942 N | irthplace (Stata or Foreign Sountry) ew York |
| | pue * | | 10a. State 10b. County | | 10c. City, | Town or Lo | ocation | | | | | | 10d. Inside City Limits |
| | ith the Maryler or 28a-f show | ō | Maryland Balt | imore | Ba | 1timo | re Cou | ints | 7 | | | | 1 ☐ Yes 2 ☐ No |
| | 28a | rec | 10e. Street end Number | | | | 10f. Zip | | | | 10g. | Citizen of Whet C | Country? |
| | th with | | 404 South Payson | Street | | | | 223 | | | | .S.A. | |
| 0 | 72 hours after deeth with the Maryland natural; or items 23a or 28a-f show deal Examiner must be notified at | Funeral Director | 11. Maritel Status 12. Was Decedent Ever in U,S. Armed Forces? 1 XNavar Married 2 Married 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes, specify Cuban, Maxican, Puerto Rican, etc.) | | | | | | | | | Bleck, Wh | |
| 020 | at', o | by | 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give Yaer or Detes: | | | 1□ Yes 2 | ⊠ No | Specify: | | | Specify: W | hite |
| 5-0 | | Completed | 15. Decedent's E | 15. Decedent's Education (Specify only highest grade completed) | | | | | petion | f working | 16b | . Kind of Busines | s/Industry |
| 2 | | npie | Elementery/Secondary (0-12) | mentery/Secondary (0-12) College (1-4or 5+) | | | | | during most o | WOINING | | | |
| 2 | ygier ygier r, | ပိ | unknown | | unknown unknown | | | | | | | | |
| /land | uld be fill Ventel H rked oth | To Be | 17. Fether's Name (First, Middle, Las William Al Jenk | 18. Mother's Neme (First, Middle, Meiden Sumeme) Doris Lucille Nash | | | | | | | | | |
| Man | nd 2 sho aith end i 27 is me | | 19e. Informent's Neme/Relationship Michael Jenkins/ | | 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Ste 10848 Downsville Pike, Hagerstown, Mar | | | | | | | | |
| Baltimore, Maryland 21215-0020 | permit. Pages 1 and 2 should be filed within Department of Health and Mentel Hygiene. Important: If item 27 is marked other than any injury or other treumatic event, the Medons. | | 20e. Method of Disposition 1 ☐ Burial 2 ☐ Crametion 3 ☐ 4 ☒ Donation 5 ☐ Other (Special Contents) | 20b. Ple car | bb. Plece of Disposition (Name of carmetery, cremetory or other pleca) Dete 20c. Location - City or Town, Stete | | | | | | r Town, Stete | | |
| Balt | Depart Depart Import any inj once | | 21. Signature of Funeral Service Licensee Ropald S. Wade, Director State Anatomy Board, 655 W. Baltimore Baltimore, Maryland 21201 | | | | | | | | | re,Street | |
| | Physician | - | Pert1. Enter the disease, or con hock, or heert feilure. List only | pplications that caused one cause on each li | tha deeth. | | | | | | | | Approximete Intervel Between Onsat and Death |
| -4 | /Medical | | Immediate Ceuse (Finel diseasa or condition | GASTRO | DINTEST | TNAI H | FMODDH/ | GE | | | | | |
| 1 | Examiner | | resulting in deeth) | ө | | es e consec | | IUE | | | | | |
| 6 | D # | Iner | _ | | | | | | | | | | |
| 0, | icate be executed physicien end s the buriel-transit | Examiner | Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events | 0 | Due to (or e | es e conseq | quenca of): | | | | | | |
| x 68760, | certificate be executed ding physicien end ise es the buriel-transit | /Medicai | Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest | с. | Due to (or a | is a conseq | juence of): | | | | | | |
| - | 0 0 0 | 2 | | u | | The second | | | | | | | |

been signed by the etter should be deteched for u Physician þ Completed After this certificate has To the Hospital or Attending Physician: within 24 hours after death.

To the Funerat Director: After this certifict completely filled in by the funeral director, I Be

2

Certification:

Medical

Division of Vital Records, P.O.

Pert II. Other eignificant conditions contributing to death but not resulting In the underlying ceuse given in Pert I.

25. Wes case referred to medical examiner?

YN Yes 2□ No

27. Menner of Deeth

1 Neturel

2 ☐ Accident 3 ☐ Suicide

4 ☐ Homicide

29e. Certifier (Check only one)

ADHESIONS COMPLICATING REMOTE COLECTOMY

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Dete of Injury (Month, Dey Year)

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home XX Residence 6 Othar (Specify) 28c. Injury et Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

26. Plece of Deeth (Check only one)

28f. Location (Street end Number or Rural Routa Number, City or Town, Stete)

24e. Wes en eutopsy performed?

1 ☑ Yes 2 ☐ No

1 Certifying Phyelclan: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

XIX Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signatura and titla of certifier

5 Pending Investigation

6 Could not be determined

29c. Licansa number OCME

29d. Dete signed (Month, Day, Year) AUGUST 25, 1997

23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ② Unknown

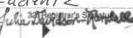
24b. Were eutopsy findings aveilable prior to completion of causa of deeth?

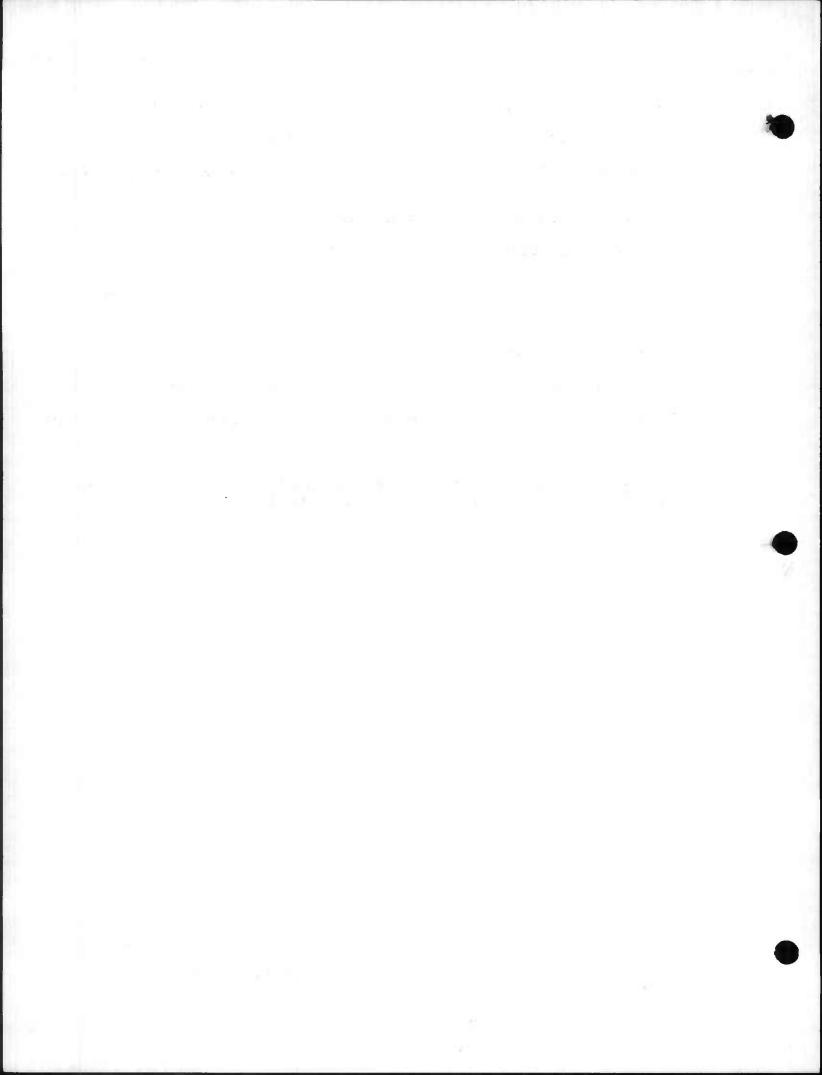
1 Yes 2 No

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 Radentz Stephen 31. Date filed (Month, Dey, Year) SEP 0 8 1997

State Registrar





State of Maryland / Department of Health and Mental Hygiene

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|-----|--------|-----|-----|---|---|---|
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| 200 | 4 | Com | - 8 | V | - | |

| | | | | | Ce | rtificate | of Death | | Reg. No. | 1 6 | 1311 | |
|--|---|---|--|--|---------------------------------|--|--|---|---|--|---|--|
| Dhunialan | | lema (First, Mid | | | | | | 2. Dete of De Month | ath Day | Yaar | 3. Time of Death | |
| Physician /Medical | Mari | e Jose | phine K | rysiak | | | | Septembe | er 8 19 | 997 | 4:37 am | |
| Examiner | | | ion, giva street and n | | | | 111 22 23 | or Location of Death | | y of Death | | |
| 4 | | | cins Bay | | | 1 1/1 | Balti | | n/a | | | |
| Funeral Director | 5. Social Securi 213-05 | -6041 | 6. Sex 1 □ M 2 ★ F | 7. Age (In yrs. 88 | last birthdey) Yrs. | | | lin. 8. Dete of Bir (Month, Da March | | | ca (State or Foreign) Lyn, NY | |
| tel Hygiene. d other than "natural", or items 23e or 28e-f show event, the Medical Examiner must be notified at Be Completed by Funeral Director | Usual Rasidano | 10b. Coun | tv | 10c. City | y, Town or Lo | ocation | | | | 104 | . Inside City Limits | |
| of gard | MD | n/a | , | | timore | | | | | 100 | 1 Yes 2 □ No | |
| ect of | 10e. Street and | | | | | 10f. Zlp Co | do | | 10g. Citizen of | What Country | | |
| r tems 23s or 28s-fs | | | 1timore | Street | | 2122 | | | | USA | | |
| rai', or items 23s or 28s-f show Examiner must be notified at 3 by Funeral Director | | us Aarried 2□ Ma ad 4□ Divorce | Armed F arried 1 \(\sum \) Yas | 2 XNo | | Was Decedant if Yas, specify (1 ☐ Yas 2 🕱 | Cuban, Maxican, Pu | (Specify Yea or No lierto Rican, etc.) | Bla | ce - American ick, Whita, etc fy: Whit |). | |
| ygiene. Ner than "natural". It, the Medical Exp | (5 | 15. Deceda Specify only high | ant'a Education rest grade completed |) | /Giva | dant'a Usual O | one during most of | working | 16b. Kind of E | lusinass/Indus | stry | |
| then then the Me | | econdary (0-12) |) Collega | (1-4or 5+) | | nstres | | | Tond | an Fac | | |
| SEE S | 4t | na (First, Middle | n death | | Seal | ustres | | Nama (First, Middla, | | on Fog | 3 | |
| Be New | | t Sava | | | | | | | | | | |
| To | | | | | 405 14-10 | - Add (0) | | | Bonocu | | | |
| 7 is r | 1 | | nship <i>(Type, Print)</i> g | | | | altimor | Rural Routa Numb | Baltime | | | |
| ther ther | 20a. Mathod of | | ystak u | | | osition (Nema d | | Dete Dete | 20c. Location | | | |
| 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | 1 🔀 Burial | 2 Cramation | 3 Removal from | Stata | emetery, cre | matory or other | r place) | | | | | |
| nlury | | on 5 Other | | Vak | | Cemeter | - | 9/10/97 | | | | |
| Important: If them 27 is marked other than "r any injury or other traumatic event, the Med once. To Be Comple | 21 Signating | Funaral Sarvic | a Licensee | and for | 20 | 53 S.; | ddress of Facility J Conkling | oseph N. St. Balti | Zannino more, N | Jr. F Marylan | uneral Had 21224 | |
| nysician | 23a. Phyt I. Ent | ar tha disaasa, chaart fallura. Li | or complications that st crify one cause on | caused the death | h. Do not an | tar tha moda of | dylng, such as care | diac or raspiratory a | rrest, | In. | pproximata iterval Batween inset and Death | |
| Medicai caminer | Immediate Cau diseesa or cond resulting in dea | dition | a | Acute | r as a consec | | ay Ep | EWA | | 1 | HRS | |
| je je | | | | ~ | | 40 % K K M | ب | | | | 199 | |
| in and tal-transit Examiner | Sequantially lis | t conditions, | Ь | | r as a consec | - | | | | | , | |
| burial- | Sequantially list if any, leading to causa. Entar U Cause (Disaase | o immediata Inderlying | | Aon | وتردد | STEN | 00010 | | | i | 4725 | |
| edic | that initiated every resulting in dea | ents | С. | Due to (or | r as a consec | | - 3 - 1 | | | | | |
| d by the attending stached for use a Physician/M | | | d | | | | | | | 1 | | |
| y the chad | Pert II. Other ele | | tions contributing to | death but not rasi | ulting In tha u | ndarlying cause | a given in Part I. | | | | ne cause of death? | |
| | | N | BNO | | | | | 10 | Yes 2 No | 3 Probat | bly 4 XUnknow | |
| pate has been signe page 2 should be c Completed by | | | | | | | | 24a. Was | an autopsy prmed? | avalis | autopsy findings able prior to eletion of cause | |
| mp ge 2 | | | | | | | | . — | ~/ | of dea | 77 77 | |
| | | | | | | | | 10 | Yas 2 No | 1 U Y | /as 2□ No | |
| rector | axaminar? | afarred to medic | Hospital: | | / | | Other | Death (Check only o | | | | |
| rai der | 1 ☐ Yes 2 27. Mannar of D | No | 28a. Data | - | ER/Outpatier 28b. Time o | | 4 LI Nursin | g Homa 5 Rasii | | | | |
| or: Atlar the fune | 1 Natural 2 Accider | 5 ☐ Pand invas | ling (Mo | nth, Pay Year) | Injury | | injury at Work? 1 ☐ Yes 2 ☐ No | 200.000 | now injury cood | 1160 | | |
| is after death, at Director: After ted in by the funeral Certification: | | 3 Sulcide 4 Homicida 6 Could not be determined 28a. Placa of Injury - At homa, farm, street, factory, offica building, etc. (Specify) | | | | | | | 28f. Location (Street end Number or Rural Route Number, City or Town, Steta) | | | |
| Funer Funer stay III | 29a. Cartifiar (Check only one) | 1 Certify 2 Medica | ing Physician: To the Examiner: On the lend ma | a bast of my know basis of examinat onar stated. | wledga, daati tion and/or in | n occurred at th | ne tima, data and pla my opinion, death o | ace, and dua to tha courred at the tima, | causa(s) and m date and placa | anner as state and dua to th | ed. la causa(s) | |
| Med | 29b. Signatura a | and title of certifi | | | | 29c. Lk | canse number | | 29d. Data signi | ed (Month, Da | y, Year) | |
| |) (| WS.W | pld m | D | | 2 | 023533 | | a/8 | 1/97 | | |
| O_1 | 30. Nama and a | ddress of person | n who completed ceu | sa of daath (Itam | | | | | | | | |
| | | CW | 5 cmo zw | W ans w | 0 ; | 2HBW1 | ट भवपा | BYSH3 (| en as | ح | | |

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Registrar

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| : Iter | ms23PartI | ,20 | State of Maryland / De Ob 9-9-97 FilmG751 W.H.Per Doctor & F/H C | partment of F ertificate of | Health and M <i>Death</i> | | ene 97 | 27318 | | | |
|------------|---|--------------------------|--|---|---|--|--|---|--------|---|--|
| | Physic: /Medi | | Decedant's Nama (First, Middle, Last) MABLE B | | 2. Dete of Death Month AUG. | Pay 1997 | 3. Time of Death 10:15 AM | | | | |
| | Examir | | 4a. Fecility Neme (If not institution, give street and number) 100 W. UNIVERSITY PARKWAY, APT. 7- | -C | 4b. City, Town, or Lo BALTIMOR If Under 24 Hrs. | RE | 4c. County of Deeth | | | | |
| | Funeral Director | | 5. Sociel Security Number 6. Sex 1 M 2 F 7. Aga (In yrs. lest birtha 92 Yrs Usuel Residence of Decedent | Months Days | Hours Min. | 8. Dete of Birth (Month, Day, Y FEB. 23, 1 | | placa (State or Foreign htry) DRGIA | | | |
| | show | | 10a. Stete 10b. County 10c. City, Town o | Location | | | | 10d. inside City Limits | | | |
| | the Maryle 28a-1 sho | ecto | MD N/A BALTII | | | | | 1 □ Yes 2 □ No | | | |
| | th with th | ral Dire | 100. Straef end Number 100 W. UNIVERSITY PARKWAY, APT. 7- | -C 212 | 10 | 10g | g. Citizen of What Cou USA | ntry? | | | |
| 020 | hours effer death with the Maryland lural", or ferre 23a or 28a-f show at Examinet must be notified at | by Funeral Director | 11. Meritel Status 1 □ Nevar Married 2 □ Merried 3 □ Midwed 4 □ Divorced 12. Wes Decedent Evar In U,S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Yeer or Detes: | 3. Was Decedent of H If Yes, specify Cub. 1 ☐ Yes 2 ☐ No | | ecify Yas or No- Rican, etc.) | 14. Race - Ameri Bleck, White, Specify: WHIT | etc. | | | |
| 21215-0020 | within 72 ane. than "nat | mpleted | Be Completed | 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 4 | cedent's Usuel Occupive kind of work done a. DO NOT use retired | during most of working) | ing 16 | Sb. Kind of Business/In | dustry | | |
| | a liled al Hygie other | le C | 17. Fether's Neme (First, Middle, Last) | TEACHER | | (First, Middle, Me | EDUCATION aiden Sumeme) | | | | |
| ylar | should be nd Mental merked o | ToE | ALEXANDER BROD | | ROSE | | GC | OLDBERG | | | |
| Maryland | d 2 sho th end 7 is m traum | | | aiting Address (Street W. UNIV. | | | City or Town, Stete, Zip | | | | |
| | ss t and 2 should be liled of Health and Mental Hyg Item 27 is marked other other traumatic event, | | 20e. Method of Disposition 20b. Place of Di | sposition (Name of | PARRWAI, I | | BALTO., Oc. Location - City or T | | | | |
| E O | ant o | | 1 Buriel 2 □ Cremetion 3 NRemoval from State 4 □ Donetion 5 □ Other (Specify) BNAI J | Jesburun SHURAN | 8/2 | 1/97 E | ELIZABETH, | NJ | | | |
| Baltimore, | permit. Pege Depertment of Important: If any injury or | | 21. Signature of Funeral Service Licensee | 22 Name and Address 8900 REI | | | KESVILLE, 1 | MD 21208 | | | |
| | 77.00 | | 23a. Party. Enter the disease, or complications that caused the deeth. Do not should or heart facure. List only one cause on each line. | | | | | Approximete Interval Between | | | |
| | Physician /Medical Examiner | ner | Immediate Cause (Final disass or condition resulting in death) e. ard presp | , | | | Onsef and Death | | | | |
| L | | | ner | Due to (or es elopr Cardiovascular Dis | | | | | | | |
| , | cete be executed physician end the buriel-transit | Examiner | Sequentially list conditions, it eny, leading to immediate cause. Enter Underlying Cause (Disease or injury | | | | | | | | |
| Box 68760, | 5 0 8 | v/Medical | Cause (Disease or injury thet initiated events rasulting in deeth) Lest Dua to (or as a condition of the co | sequence of): | | | | | | | |
| | e death certifi the ettending hed for use as | siciar | Pert II. Other significant conditions contributing to death but not resulting in the | e undertving cause giv | van in Pert i. | 23b. Did toba | acco usa contribute 1 | o the cause of death? | | | |
| , P.O | ± ≥ 5 | Completed by Physician/M | by | b | by | 110 | ssure hydrocephalus | | | 20 No 3□ Pro | |
| Records, | lew requires that les been signed b 2 should be dett | | | | | V | | | | 24e. Wes en eutopsy performed? 24b. Were autopsy findi aveilable prior to completion of caus of death? | |
| | The ate h | | 25. Wes cese referred to medical | | 00 Div. (D. 11 | 1 ☐ Yes | 2XN0 1 | Yes 2 No | | | |
| of Vital | Physician: this certific ral director, | To Be | exeminer? 1 Yes 2 No Hospitel: 1 inpelient 2 EP/Outpa | tient 3 DOA Oth | 26. Plece of Deeth | 1 | ce 6 □Other (Speci | ify) | | | |
| 0 0 | ding Phys h. After this funeral di | | 27. Mennar of Deeth Neturel 5 ☐ Pending 28e. Dete of Injury (Month, Day Year) Inju | y) Wo | | 28d. Describe how | Injury occurred | | | | |
| Division | or Attending after death. Director: After d in by the fune | Icati | 2 Accident Investigation NA N | | Yes 2□N6 | 28f Location /Stre | et end Number or Rur | ral Roule Number | | | |
| Div | s after I Directly of in b | Certification: | 4 Homicide determined determined 28e. Piece of Injury - At home, ferm building, etc. (Specify) | NA | | City or Town, | Stete) | ar riodio rrombo, | | | |
| | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely lilled in by the funeral | Medical (| 29e. Certifier (Check only one) Certifying Physician: To the best of my knowledge, do not be the best of examinetion end/or end menner steted. | eth occurred at the tir investigation, in my o | me, dete end plece, opplnion, deeth occurr | end due to the ceu ed et the time, det | se(s) end menner as see and place, end due t | steted. to the ceuse(s) | | | |
| | To the To the comp | Σ | 29b. Signeture end title of certifier Fanet Horn M | 29c. Licens | 2516° | 290 | d. Dete signed Month, | Pay, Year) | | | |
| | | | 30. Name and address of parson who completed cause of deeth (Item 23a) (Ty Janct Horn Mb 10755 Falls | pe Print) 12d Lut | herville | , MD Z | 1 | | | | |
| 1 | Sta Registr | | 31. Dete filed (Month, Dey, Year) SEP 0 8 1997 | £ ₀ | | | | | | | |

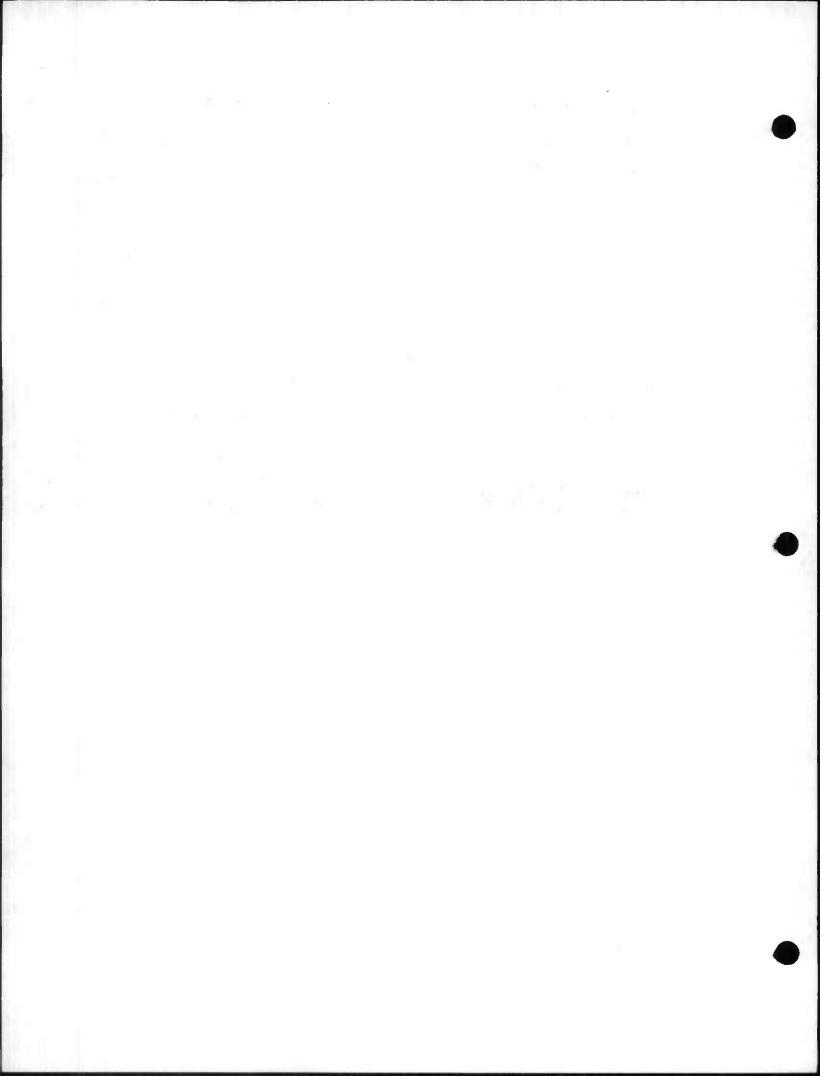
DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physiclan** 09707/97 Dey 11:40 PM John James Kaptain /Medical 4a. Fecility Nama (If not institution, giva street and numbar) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 816 Arncliff Road Baltimore Baltimore 5. Social Security Number If Under 1 Yaar If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Yaar) Birthplaca (Stata or Foraign Country) **Funeral** Days Months Hours 1☐XM 2□ F Yrs. 215-03-7449 Director 90 01/01/1907 Maryland Usual Rasidenca of Dacadant with the Meryland 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Insida City Limits traumatic avent, the Medical Examiner must be notified at N/A MD Baltimore 1 Yas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 6 U.S.A. 21224 Herns 23a 633 S. Lehigh Street Funeral nit. Pages 1 and 2 should be filed within 72 hours efter death varefrment of Health and Mental Hygiene.
ortant: if item 27 is marked other than "natural; or items 23.
Injury or other traumatic avent, fin Medical Estantics multipliury or other traumatic avent, fin Medical Estantics multipliury or other traumatic avent, fin Medical Estantics multipli 12. Was Dacadant Ever In U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, etc.) Raca - Amarican Indian, Bleck, White, etc. 1 ☐ Yas 2 ☑ No If Yas, Giva Year or Datas: 1 Navar Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yas 2X No Specify: þ Specify: White 3 Widowad 4 □ Divorcad Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use ratired) 15. Dacadant's Education (Specify only highast grade complated) 16b. Kind of Businass/Industry Elamentary/Sacondary (0-12) Collaga (1-4or 5+) Car Lot chauffeur 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumame) Be Elizabeth Heimel Frank Kaptain 10 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) 7177 Eastbrook Avenue Baltimore, Maryland 21224 19a. Informent's Name/Relationship (Type, Print) Jo Anne Day 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 1 ☐xBurlet 2 ☐ Cramation 3 ☐ Ramoval from Stata Department of important: If any injury or once. Holy Redeemer Cemetery 9/11/97 Baltimore, Maryland 4 Donation 5 Other (Specify) Al Sarvica License 22. Nama and Address of Facility The Dippel Funeral Home Inc. 7110 Belair Road Baltimore, Maryland 21206 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heer failure. List only one cause on each line. Approximata tntarval Between Onsat and Deeth **Physician** /Medical Immediate Causa (Final disaesa or condition rasulting in daath) HSpiretian . **Examiner** Dua to (or as a consequence of) Examiner Elaphyoral The law requires that the death certificete be executed bunel-transit Sequantielly list conditions, if any, laading to Immadiata causa. Enter Underlying Cause (Diseesa or trijury that initieted avents rasulting In deeth) Last Dua to (or es a consequança of): and Box 68760, ettending physician AJCVD Physician/Medical the Dua to (or es a consequança of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? ate hes been signed by page 2 should be detact 1 Yes 2 No 30 Probably 4 Unknown by 24b Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 20No 1 □Yas 2 □ No certificate Hospital or Attending Physicien: 24 hours efter death. Funeral Director: After this certifica Be 25. Was case rafarred to medical 26. Placa of Death (Check only ona) exeminar? Hospital: Othar: 4 Nursing Homa SPResidanca 6 Othar (Specify) 2 1 Inpatiant 2 ER/Outpatiant 3 DOA funeral 28c. Injury at Work? 28d. Describe how injury occurred 27. Mannar of Death 28a. Data of Injury (Month, Day Year) Certification: 28b. Time of Naturel 2 Accidant 5 Pending Invastigation To the Hospital or Attendir within 24 hours effer death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yas 2 ☐ No 6 Could not be datarminad 3 Suicide 28e. Placa of Injury - At homa, farm, street, factory, offica building, etc. (Specify) 281. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 4 Homicide Certifying Phyatotan: To tha best of my knowledge, deeth occurred at tha time, date end pleca, and dua to the cause(s) and menner es stated.

| Madicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and dua to the cause(s) and mannar stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Data signed (Month, Day, Year) 29c. Licansa number and addrass of person who complated causa of deeth (Item-23e) (Type, Pint) 32. Registrar's Signature e, 2801 Hudson St. 21224 31. Date filed (Month, Day, Year) State SEP 0 9 1997 Registrar

DHMH 16 Rev 6/95



| State of Maryland / Department of Health and Mental Hygiene 9 | |
|---|--|
| Contidents of Double | |

| | | | State of I | Maryland | | | of Health and I of Death | | gieney / Reg. No. | 21 | 320 | | | | | | | | | | | | | |
|--|----------------|--|---|---|---|------------------|--|--------------------------------------|------------------------------------|---------------------------------|---|---|---------------|---|---|------------------|---|----------------|---|-------------------|---------------------|--------|---|--|
| Physician | | Decedent's Nama (First, Middle | • | | | 0) | | 2. Dete of De Month | eth Dey | Year | 3. Time of Deeth | | | | | | | | | | | | | |
| /Medical | | ISLANCITE | | KIRCHMAN | | SEPT | 6 6 | 797 | 1920 | | | | | | | | | | | | | | | |
| Examiner | | te. Facility Na <i>me (If</i> not institution Anne Arundel | | | | | | Anne Arundel | | del | | | | | | | | | | | | | | |
| Funeral Director | | 5. Social Security Number 508 10 6658 | 6. Sex 7 1 ☐ M 2 ☐ F | Age (In yrs. la 93 | st birthdey) Yrs. | Months D | 'aar If Undar 24 Hrs. eys Hours Min. | 8. Date of Bir (Month, De Sept | th ly, <i>Year)</i> 30 190 | | e (Stete or Foreign) Wa | | | | | | | | | | | | | |
| r 28a-f show | | Usuei Residenca of Decedent 10e, Steta 10b, County Md Anne | Arundel | | Town or Loc | | | | | 10d | Inside City Limits 1 ☐ Yas 2 ☐ No | | | | | | | | | | | | | |
| 3a or 28 at be not | | 10e. Street and Number 703 N. Rivers | side Drive | е | | 10f. Zip Co | 4032 | | 10g. Citizen of V | | ? | | | | | | | | | | | | | |
| within 72 hours aftar death with the Maryland ene. Hand "netural", or items 23a or 28a-f show the Medical Examiner must be northed at the Medical Examiner must be northed at the Medical Examiner must be northed at the Medical Examiner must be northed at the Maryland Maryland Maryland Maryland at the Maryland Maryland Maryland Maryland Anners of the Maryland Ma | De completed | | | 1 | by runers | by runera | 1 In let | Dy Funera | Dy Funera | Dy ruiler | 11. Marital Stetus 1 □ Never Merried 2 □ Marri 3 □ Widowed 4 □ Divorced | 12. Was Decede Armed Force ed 1 Yes 2 If Yes, Give Yaer or Dete | s? XNo | J,S. 13. Wes Decedent of he if Yas, specify Cub | | | of Hispanic Origin? (Specify Yas or Nouban, Mexicen, Puerto Rican, etc.) No Specify: | | 14. Race - American Ind Black, White, etc. Whit Specify: | | | | | |
| Minin (2 118 Men "netur Medical | | | | 15. Decedent (Specify only highes Eiementery/Secondery (0-12) | t grade completed) College (1-4c | or 5+) | 18e. Decedent's Usuel Occupatio (Give kind of work done duri iife. DO NOT use retired) School Teac | | lone during most of wor etired) | e during most of working ed) | | 16b. Kind of Bueiness/Industry Education | | | | | | | | | | | | |
| d other event, the Be Co | | 12 17. Fathar's Nema (First, Middle, I Theodore A | 4 ^{Last)} . Lindenm | eyer | 3011 | 001 1 | 18. Mother's Nan DaisyV | | | | 110 | | | | | | | | | | | | | |
| traum | | 19e. Informent's Neme/Reletionsh RObert Kirchi | nip (Type Print) nan/Son | | 19b. Meiling 143 | Address (Si | treet end Number or Au | | er, City or Town, Mass. | State, Zio C | 775 | | | | | | | | | | | | | |
| oth oth | 1 | 20a. Method of Disposition 1 → Buriai 2 □ Cremetion 4 □ Donetion 5 □ Other (Sp | | | eca of Dispos matary, cremi apoli | | rplece) | Sept 1 | 20c. Location - Annapo | City or Town | , State 1d | | | | | | | | | | | | | |
| permit. Page Department of Important: If any injury or once. | П | 21. Signature of Funeral Service I | 1 2/ | 0 () | 22. Ha | Nama and A | ddrass of Facility | l Home | P.A., | 12 R: | idgely | | | | | | | | | | | | | |
| Physician | dical Examiner | 23a. Part1. Enter the disease, or shock, or heart fellure. List | complications that caus only one cause on each | ed the dealth | Do not ente | r the mode of | dying, such es cardied | or respiretory a | rrest, | in | pproximate tervai Between nset and Deeth | | | | | | | | | | | | | |
| /Medical Examiner | | dical Examiner | Immediate Cause (Finel disaase or condition resulting in deeth) | e. Co | | STIV (| | HEART | FAILU | RE | 1 | MONTH | | | | | | | | | | | | |
| and Il-transit Xamine | | | Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury | b | Due to (or | es e consequ | enca of): | | | | | - | | | | | | | | | | | | |
| physicla the bur | | | dical | in Cal | dical | dical | dical | dical | clan/Medical | dical | dical | dical | dical | dical | Cause (Disease or injury that Initiated events Dua to (or as a consequence of): | | | | | | | | | |
| attanding p d for usa as | | | | | | | | | | | Pert II. Other significant condition | ne contributing to death | but not recul | ting in the un | dorhalag og ug | e given in Red I | 22h Did | tobacco use co | ntribute to th | e cause of death? | | | | |
| y th | | on in outer against to to to to | to death | | ung in are and | Jerry III g Caus | o gwell ii Pelt I. | 1 🗆 | | 3 Probet | | | | | | | | | | | | | | |
| 2 should | pierce D | | | 2000 | pieted by | חפופת הא | pieted by | pieted by | pieted by | pound of | | to possed | | | | | | | | | en autopsy rmed? | availe | autopsy findings ble prior to letion of causa eth? | |
| cata he | | | | | | | | 10 | Yes 200 | 101 | as 2 No | | | | | | | | | | | | | |
| certificata | | 25. Wes casa referred to medical examiner? | Hospitel: | | | | Other: | ath (Check only o | one) | | | | | | | | | | | | | | | |
| 를 들 다 | | 1 ☐ Yes 20 No 27, Mannar of Death | 28a. Date of Ir | | R/Outpatient | 3□ DOA | 4 Li Nursing H | oma 5 Resident | dance 8 Oth | | | | | | | | | | | | | | | |
| o Fa | | 1 Neturel 5 Pending | (Month, L | Dey Year) | 28b. Tima of Injury | | injury at Work? 1 ☐ Yes 2 ☐ No | 260. Dascribe | now injury occur | 160 | | | | | | | | | | | | | | |
| 24 hours after death. • Funeral Director: After tetaly filled in by the funeral dical Certification: | | 3 Suicide 6 Could n 4 Homicida | ot be 28e. Piaca of | Injury - At hon etc. (Specify) | ne, ferm, stre | | | 28f. Location (: City or To | Street end Numb wn, Stete) | per or Rural R | loute Number, | | | | | | | | | | | | | |
| 4 hours | | 29a. Certifier (Check only one) Certifying | Physician: To the bes Examiner: On the basis and manner | of examinetic | iedge, death on end/or inva | occurred et the | he time, dete end pleca my oplnion, daeth occu | , and due to the rred et the tima, | cause(s) and modele and place, | enner es stete and due to th | ed. a cause(s) | | | | | | | | | | | | | |
| To the Vithin 2 To the I complei | | 29b. Signeture and title of certifier | 11 - | | | 29c. Li | cense nu <i>m</i> ber | | 29d. Dete signe | d (Month, De | y, Year) | | | | | | | | | | | | | |

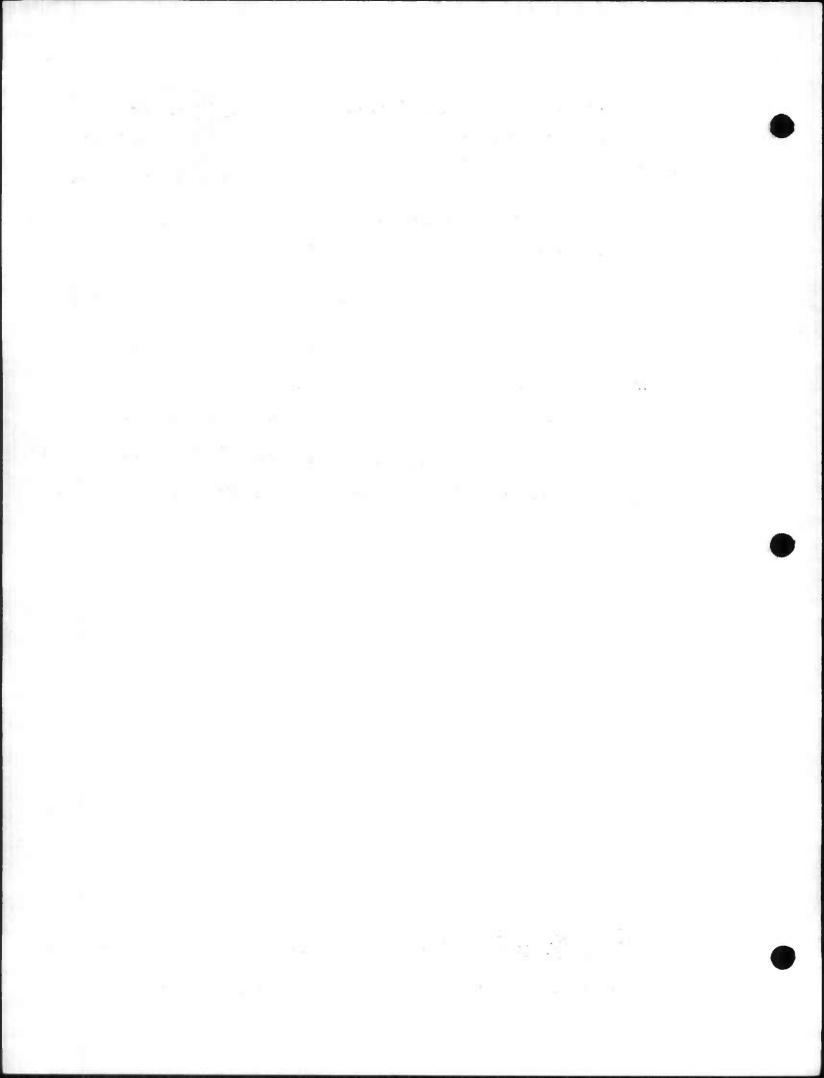
30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

Enser W. Cole, MD, 900 Best Gate Rd., Annapolis, Md 21401 31. Date filed (Month, Dey, Year)

State Registrar

SEP 0 9 1997

32. Registrer's Signature



State of Maryland / Department of Health and Mental Hygiene 27321 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** Vesi KAUFMAN BRUCE HLAN SEPTEMBER 5 , 1997 03:40 AM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A JOHNS HOPKINS HUSPITAL BALTIMORE CITY 7. Age (In yrs. lest birthday) If Under 1 Year If Undar 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Dev. Year) Months Days 1**%** M 2□ F 50 Yrs. Hours 212-46-1732 Director SEPT.9,1946 MARYLAND. Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f show ahow Director CHEVY CHASE ty Yes 2 □ No MONTGOMERY 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8 must be flarms 23a 5610 WISCONSIN AVE., A PT. 1607 20815 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14 Bace - American Indian Black, Whita, atc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No 6 1 ☐ Yes 2 No Specify: 215-0020 à WHITE 3 ☐ Widowed 4 ☐ Divorcad Year or Dates: mpleted 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 5+ ATTORNEY AT LAW 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) **HERMAN** KAUFMAN BERTHA **GUNDERSHEIMER** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20815 5610 WISCONSIN AVE., APT. 1607 ARLENE KAUFMAN (WIFE) CHEVY CHASE, MD Dapartment of Health Important: If Item 27 altimore, 20a. Method of Disposition
1 ☑ Bunial 2 ☐ Cramation 3 ☐ Removal from State 20h. Place of Disposition (Neme of 20c. Location - City or Town, State cemetery, cremetory or other place) 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW 9/7/97 REISTERSTOWN, MD Mure of Funeral Service Lic 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each line. Approximata Intervei Between Onset and Death Physician /Medicai Immediate Cause (Final PANCREATIC CANCER disease or condition resulting in death) FOUR WEEKS **Examiner** Examiner certificate be executed physician and s the buriel-tran Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of) P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b þ Records. 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 1 ☐ Yes 2 XNo certificate Vital l or Attending Physician: efter death. director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No of funeral 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After Division 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital or within 24 hours eff To the Funeral Di completely filled in 180 Cartifying Physician: To the best of my knowledge, death occurred at the time, dete and placa, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. edical 29a, Certifier (Check only 29c. Licansa number 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Yeer) SEPTEMBER 5, 1997 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

JOHN'S HOPKINS HOSPITAL BALTIMORE, MD

Registrar

MATTHEW T. YEATMAN, M.D.

32. Régistrar's Signeture

gilia Davidson

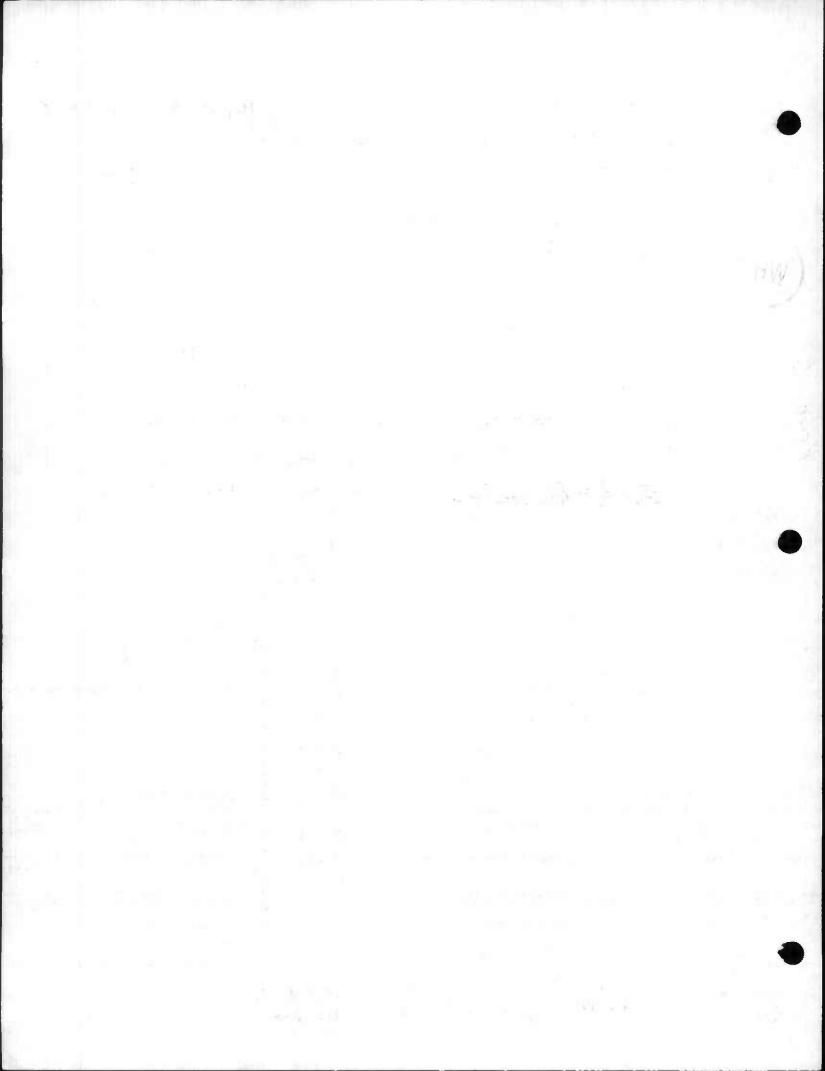
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31. Date filed (Month, Day, Year) SEP 0 9 1997

DHMH 16 Ray 6/95

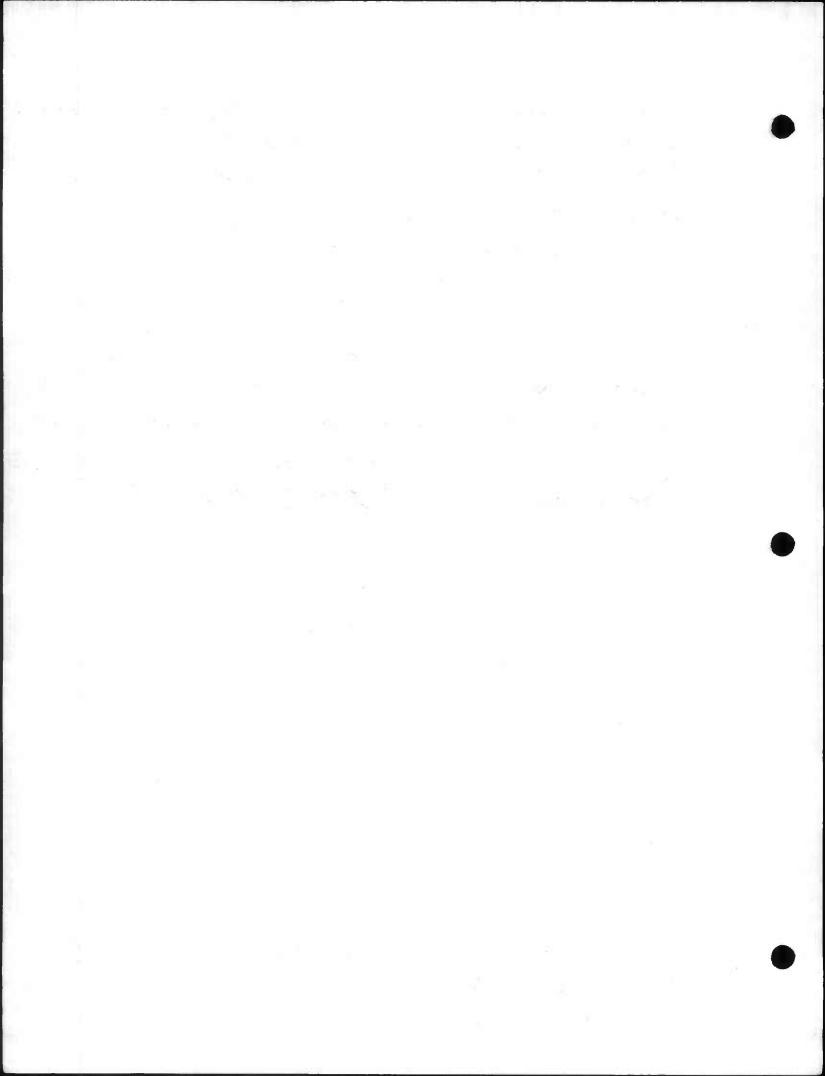
State of Maryland / Department of Health and Mental Hygiene 97 27322

| | | 1. Decedent's Neme (First, Mi | iddle, Las | it) | | | | | | 2. Date of | | . No. | V | 3. Time of Death |
|--|----------------------------------|--|--|--|--|---|--|------------------------|---|--|---|---|--|--|
| ıysiclar Medica | _ | Guy Minnicl | k Ke | eirn | | | | | | Augu | st | Day 30 | 1997 | 2208 |
| camine | | 4e. Facility Name (If not institu | ition, give | street end nu | mber) | | | | 4b. City, Town | or Location of D | | 4c. County | | |
| | | Fallston G | ener | al Ho | spita | al | | | Falls | ton | | Harf | ord | |
| ral lor | | 5. Social Sacurity Number 171-07-0860 | | ex XM 2□F | 7. Age (In) 88 | yrs. last birth Y | rs. If Und Month | der 1 Yeer Is Days | | Hrs. 8. Date of (Month) May 2 | Birth Dey, Y | 909 | Count | aca (Steta or Foreig try) Ona, PA. |
| 100 | | Usual Residence of Decadent 10a. State 10b. Cour | | | 10c. | . City, Town | or Location | | | | | | 10 | Od. Insida City Limits |
| Director | 900 | Maryland Har | ford | | H | lavre | de Gra | | | | | | | 1 □ Yas 2 💢 No |
| 2 2 | rai Dir | 421 Rock Run | Plac | се | | | | Zip Coda 21078 | | | | U.S.A | | try? |
| 2 | by Funeral | 11. Marital Status 1 □ Navar Married 2 □ M 3 ☒ Widowed 4 □ Divorce | | 12. Was Dece Armed Fo 1 Tes If Yes, Giv Yeer or Do | rces? 2 X No | n U,S. | | | Hispanic Orlgin ban, Mexican, P Specify: | ? (Specify Yes or uerto Rican, atc.) | No- | | ck, White, e | |
| i di | Completed | 15. Deced (Specify only high | dent's Edu hest grad | ucation de com <i>pleted)</i> | | 16a. D | Decedent's Us 'Give kind of y | sual Occu work done | pation during most of ed) | working | 16 | b. Kind of B | usiness/Ind | ustry |
| 1 | E | Elementary/Secondery (0-12 | 2) | College (1 | -4or 5+) | | | | | | | د د د المحاد ا | - 0 D | |
| | | 11th. 17. Father's Neme (First, Middle | lle. Lest) | n/a | | 100. | l & Die | е мак | | Name (First, Mid | | lartin | | endix |
| B | ď | Max Keirn | , | | | | | | Emma (| | 074, 1714 | our carrier | | |
| F | = - | 19a. Informant's Name/Retation | onship (Ti | vne Print) | | 19h J | Mailing Addra | ace (Stran | | Rural Route Nu | mhar C | ih. or Tour | Ctata Tin | Code |
| | | Lois Tart | | (Daught | er) | | | | | Havre | | | | - |
| | - | 20a. Method of Disposition | | (Baogine | | b. Place of D | Disposition (N | lema of | | Date | | c. Location - | | |
| OUCE. | | 1 ☑ Suriel 2 ☐ Cremetio 4 ☐ Donation 5 ☐ Other | | | | | r Memo: | | , | 9/3/97 | | el Air | | , 0 |
| DC# | | 21. Signature of Funeral Sarvice | ce Licens | 7 | 1 | 1 | 22. Name e | end Addre | ess of Fecility | | | | - | |
| 8 OI | | E 113 | 1 | | | | | 200 | ahn Fur | eral Ho | ne | | | |
| | T | 23a. Part1. Enter the disease, shock, or heart failure. L | or compl | lications that cone couse on e | aused the deach line. | leath. Do no | E F 11750 of enter the mo | Bela ode of dyl | ng, such es car | Kings diac or respiretor | vill y errest, | e, Md | | Approximate Interval Between |
| al er | | 23a. Part1. Enter the disease, shock, or heart failure. L' immediate Ceuse (Final disease or condition resulting in deeth) | or compl lst only o | lications that cone ceuse on e | esti | wu | 11750 of enter the mo | ode of dyl | ng, such es car | Kings diac or respiretor | y errest, | | | Approximate |
| Medical Examiner | Medical | immediate Ceuse (Final disease or condition | or complete or com | lications that come couse on eight | Due to | o (or es e co | lest | ode of dyl | ng, such es car | diac or respiretor | y errest, | | | Approximate Interval Between Onset and Daath |
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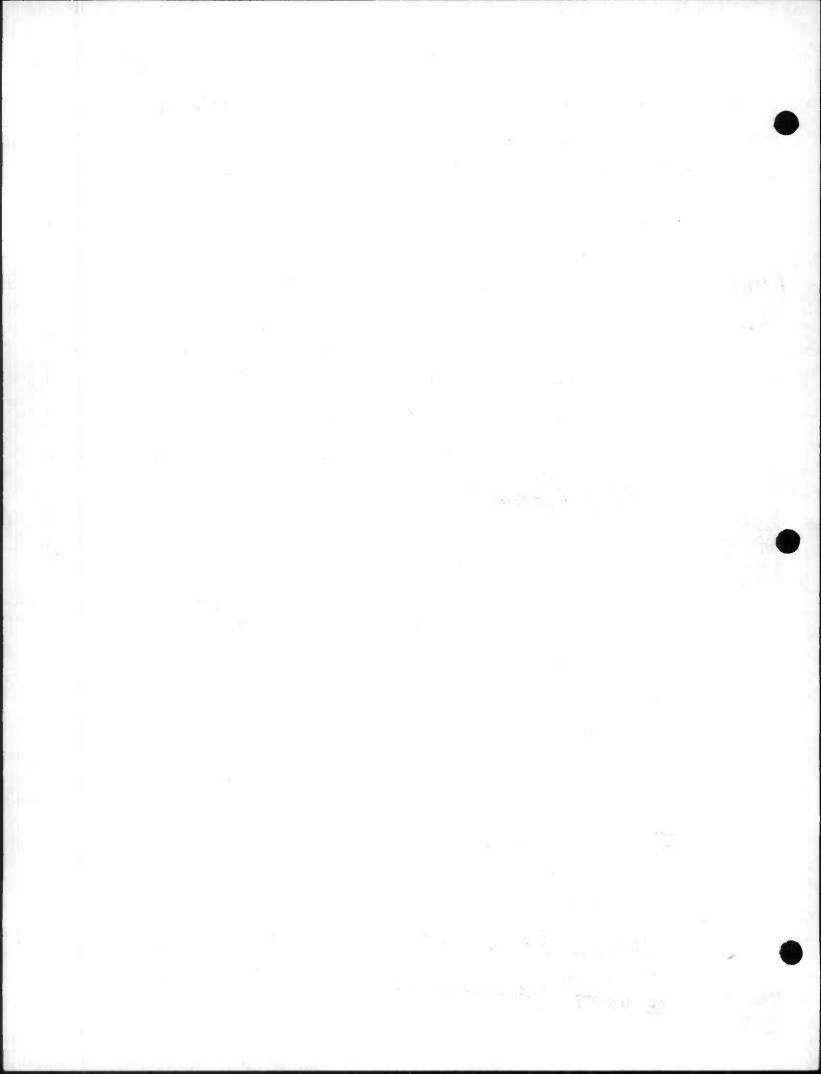
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | Certificate of Death | | Reg. No. | 1 21323 |
|--|-----------------------|--|-----------------------------------|---------------------------------------|--|
| Physic | | 1. Decedent's Name (First, Middle, Last) Joseph W. Krimmelbein | 2. Dete of De Month | Day | Yeer 4:15 AA |
| /Medi Exami | | 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Lo | cation of Deet | h 4c. County o | |
| | | Baltimore Veterans Affairs Medical Center Baltimore | | | /A |
| Funeral Director | | 5. Social Security Number 6. Sex 1 214-20-7517 6. Sex 1 2 F 7. Age (In yrs. last birthdey) 70 Yrs. 6. Sex 1 2 Months Days Hours Min. | 8. Dete of Bir (Month, Da | 19, 1927 | Birthplace (State or Foreign Country) Maryland |
| ehow ed at | Į. | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland N/A Baltimore | iai cii | 13/132 | 10d. Inside City Limits |
| death with the Maryland ms 23a or 28=4 show rmst be notified at | Funeral Director | 10e. Street end Number 10f. Zip Code | | 10g. Citizen of W | |
| eath wi | eral | 3308 Washington Boulevard 21227 11. Maritel Status 12. Wes Decedent Ever in U.S. 13. Wes Decedent of Hispenic Origin? (Spe | | United | States - American Indian, |
| 8 | þ | 11. Maritel Status 1 □ Never Merried 3 □ Widowed 4 □ Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 6 - 4 4 15 □ Yes 2 □ No | Rican, etc.) | Bieck Specify: | k, White, etc. |
| ENAL S | Completed | 15. Decedant's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) Collega (1-4or 5+) | ng | 16b. Kind of Bus | |
| nd 2 | | 12 truck driver 17. Father's Name (First, Middle, Last) 18. Mother's Name | (Final Adiabetta | trucki | |
| Maryland d 2 should be filed the end Mentel Hyg 7 is marked othe traumetic event, | To Be | 17. Father's Name (First, Middle, Last) Lewis Krimmelbein Mary Ke | | | 9) |
| Maryla d 2 should th end Men T is marks traumatic | F | 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rura | | | Stete, Zip Code) |
| | | Isabelle V. Krimmelbein, wife 3308 Washington E | | | |
| Baltimore, Marylai semit. Peges 1 and 2 should b spartment of Heelth and Ment mportant: If them 27 is marked my Injury or other treumstic e my Injury or other treumstic e mote. | | 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other piece) 20b. Plece of Disposition (Neme of cemetery, cremetory or other piece) Clen Haven Cemetery 9/ | Dete /11/97 | | City or Town, State |
| Baltimo permit. Peges Department of Important: If it any Injury or once. | | 21. Structure of Funciel Service Licensee 22. Name and Address of Facility Amb | rose | Funeral | |
| | | 23a. Part1. Enter the disease, or combilications that caused the death. Do not enter the mode of dyling, such as cardiac o shock, or heart failure. List only one cause on each line. | r raspiratory a | 227 rrest, | Approximate interval Between |
| Physician /Medical Examiner | | Immediate Cause (Final disease or condition rasulting in death) Acidosis Due to (or as e consequence of): | | | Onset and Death |
| cuted nd ransit | Examiner | Sequentially list conditions. Acute Renal Failure Due to (or as a consequence of): | | | |
| I Records, P.O. Box 68760, The law requires that the deeth certificate be executed tte has been signed by the attending physician and page 2 should be detached for use as the burial-transit | edical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In deeth) Last Due to (or as a consequence of): Congostive Heart Failure Due to (or as a consequence of): | | | |
| Box 6 eeth certifi attending | Physician/N | d | | | |
| P.O. | ysic | Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. | 23b. Did | tobacco use con | tribute to the cause of death? |
| ds, P.O. I | | Hypocoagulable state | 10 | Yes 2 No | 3 Probably 4 Mulinown |
| ecord | Completed by | | 24a. Was | an autopsy ormed? | 24b. Wara autopsy findings aveilable prior to completion of cause of death? |
| The H | Con | | 10 | Yes 20 No | 1 Yes 2 No |
| f Vital Re ysicien: The lav s certificate has director, page 2 | Be | 25. Was case refarred to medical axaminer? Hospital: Other: | (Check only o | one) | |
| n of Phys her this meral di | itlon: To | 1 2Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Hor | | dence 6 Othe | |
| Divisio To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the to | edical Certification: | 2 Sulaido 6 Could not be | 28f. Location (City or To | | er or Rural Route Number, |
| Divi | dical (| 29a. Certifying Physician: To the best of my knowledge, death occurred at tha time, dete and place, a control one) Check only one) Certifying Physician: To the best of my knowledge, death occurred at tha time, dete and place, a control of the death occurred at the time, dete and place, a control of the death occurred at the time, dete and place, a control of the death occurred at the time, dete and place, a control of the death occurred at the time, dete and place, a control of the death occurred at the time, dete and place, a control of the death occurred at the time, dete and place, a control of the death occurred at the time, dete and place, a control of the death occurred at the time, dete and place, a control of the death occurred at the time, dete and place, a control of the death occurred at the time, determined the death occurred at the time, determined the death occurred at the time, determined the death occurred at the time, determined the death occurred at the de | and due to the ed at the time, | cause(s) and man dete end plece, a | nner as stated. nd due to the causa(s) |
| Vithin Fo the | Me | 29b. Signature end title of certifier 29c. License number | | 29d. Dete signed | (Month, Day, Year) |
| | - | P11760 | | 09/0 | 7/97 |
| 10 | | 30. Name and addrass of person who completed causa of daath (Itam 23a) (Type, Print) Jin Hur, MD 10 North Greene Street, Ba 31. Deterfield (Month, Day, Year) 32. Registrat's Stornature | Himne | e Mai | yland 21201 |
| Sta | te | | . 1 1 | - / | 1 |
| Registi | ar | SEP 0 9 1997 Mula Davidur Brode 00 | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0.7

| N. S. C. | | a-f per MD G-751 9/26, 1. Decedant's Name (First, Middla, | | | Certific | ate of | Death | 2. Dete of D | | | 2 / 3 2 4 3. Time of Deeth |
|---|------------------|---|---|--------------------------------|---|---------------------------------------|---|--|--|--------------------------------------|---|
| Physic /Medi | | Edward C. Kuc | harski - | Koch | ie | | | Septem | Day | 99 ⁷ | 2:21 pm |
| Exami | | 4a. Fecility Neme (If not institution, g | | , | | | 4b. City, Town, o | | th 4c. Coun | ty of Deeth | |
| 2000 | | John Hopkins Bay 5. Sociel Security Number 6 | | al Cei | | nder 1 Yeer | Baltimo | _ | i.eh | l a pro- | |
| Funeral Director | | 190 01 6732 Usuel Residence of Decedent | 100 M 2□ F | 86 | Yrs. Mon | | | 8. Dete of B | ,1910 | Count | ece (Stete or Foreign ry) sylvania |
| the Maryland 28a-f show | | 10e. Stete 10b. County | | 10c. City | , Town or Location | | | | | 10 | Od. Inside City Limits |
| the Marylar 28a-1 show | octo | Maryland Baltimo | re | Mie | ddle Rive | er | | | | | 1 ☐ Yas 2 No |
| 2 a or 2 | Funeral Director | 10e. Street end Number 1120 Burke Road | | | 10f. | Zip Code 21 | 221 | 130 | 10g. Citizen of | What Count USA | try? |
| WI | by | 11. Marital Status 1 ☐ Nevar Married 2 【 Marriad 3 ☐ Widowed 4 ☐ Divorcad | 12. Wes Decedent Armed Forces 1 | ? No | If Yes, | acadant of I specify Cub s 2 No | Hispenic Origin? (ean, Mexicen, Pue Specify: | Specify Yes or N rto Rican, etc.) | o- 14. Ra Blo Speci | ca - America eck, White, e fy: | |
| 21215- d within Ea piere. r then 'n the | Completed | 15. Decedent's (Specify only highast of Elementery/Secondary (0-12) | Education grade completed) College (1-4or | 5+) | 16e. Decedent's U (Give kind of lifa. DO NO | | | orking | 16b. Kind of E | | |
| | e Co | 17. Fathar's Name (First, Middla, La | st) | | Liaison | Endin | T | me (First, Middle | | | arry |
| uld be Mental rked tic ev | To Be | Leon Kuchars | ki | | | | Veronio | | The state of the s | , | |
| y Mal ylallo and 2 should be like alth and Mental Hy 127 is marked one ar traumatic event | | 19e. Informent's Neme/Reletionship Stella M. Kuchar | | e) | 19b. Meiling Add 1120 Bur | ress (Stree ke Ro | end Number or Fo | du <i>ral Route N</i> umi Le River | ber, City or Town , Maryla | and 21 | ^{Code)} 220 |
| Baltimore, bernit. Pages 1 en bepertnant of Heal mportant: if item 2 iny injury or other | | 20e. Method of Disposition 1. Shurial 2 Cramation 3 4 Donation 5 Other (Spec | □Removal from State | | ece of Disposition (metery, cremetory y Rosary | or other ple | | Dete 0/1997 | 20c. Location Baltim | | wn, Stete iaryland |
| Balting permit. Pa Depertman Important: any injury | | 21. Signetura of Ameral Service Lic | To form | lo. | | | Fühera Castern A | | | land 2 | 1221 |
| 12 10 18 | | 23a. Parth. Enter tha disease, or co shock, or heart fellura. List on | mplications that causa | d the deeth. | | | | | | | Approximata |
| Physician /Medical Examiner | | Immediate Cause (Final disaase or condition | | | rachi | | 4 4 | | | 1 | Intarval Betwaen Onsat and Deeth |
| CAdminer | 10 | resulting In death) | 0. | | es e consequence | | | | | | |
| uted d ansit | Examiner | | b | | umon | | | A | D KAMINER | | |
| ata be executed thysician and the burial-transit | | Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events | | Due to (or | es a consequence | 01): | | In Which I | EDICAL E | | |
| E 08 | Medicai | thet initiated events resulting in deeth) Lest | C | Due to (or o | es e c <i>on</i> sequence | of): | Donald | N APPROVED BY | | | |
| death cartification of for use es | lan/ | | d | | | | CERTIFIC | | | | |
| d by the | Physiclan/M | Pert II. Other significant conditions | contributing to death t | out not resul | ting in the undarlyir | ig ceuse gi | van In Pert I. | 23b. Dld | Yes 2 No | ontribute to | the cause of death? |
| requires been sign should be | Completed by | | | | | | | 24e. Wes | s en eutopsy ormed? | avai | re autopsy findings leble prior to aplation of ceusa eeth? |
| The lay ate has page 2 | шо | | | | | | | 1 🗆 | Yas No | | Yes 20 No |
| ysician: The | Be | 25. Was case referred to medicel exeminer? | | | | | 26. Plece of De | eth (Check only | ona) | | 35 404130 |
| Phys ratidis | 2 | 1 ☐ Yas 2 No 27. Menner of Deeth | Hospitel: 1 Inpatie | iry 2 | R/Outpatient 3 28b. Time of Injury | DOA Oth | 4 LI Nursing I | doma 5 ☐ Res 28d. Describe | Idence 6 Ott | | |
| l or Attending after deeth. Director: After | catic | 2 Accident Investigation | on 8-24-97 | | ınk n own M | | Yes 2/XNo | - | m ladder | | |
| al or Att after d I Direct d in by | Certification: | 3 Suicide 8 Could not 4 Homicide determine | d 286. Piece of in | jury - At hom ic. (Specify) | ne, ferm, street, fec | tory, office | | 281. Location (City or To Balto., M | (Street and Num. wn, Stete) 112 | ber or Aural O Burke | Route Number, |
| To the Hospital or Attending Ph Within 24 hours after deeth. To the Funeral Director: After th completaly filled in by the funeral | edicai C | 29e. Certifier 1 Certifying P (Check only one) 2 Madical Exa | hysician: To the best miner: On the basis o end menner st | f examinetic | edge, deeth occurr on end/or Investiget | ed et the tir ion, in my o | me, dete end plece plnion, deeth occi | end due to the | cause/s) and m | enner as ste and due to t | ted. the cause(s) |
| To th To th comp | | 29b. Signeture and titla of certifiar | 01 1 | 11 | | 29c. Licans | a number | | 29d. Data signe | ed (Month, D | ay, Year) |
| σ_{i} | - | 30. Neme and eddress of person who | completed ceuse of c | death (Item 2 | 23a) (Type, Print) | 7+ | -051 | | 7/7 | 19 | |
| \ | | Meliha SV | about | 240 | ndstag ! | em. | Ave. | Baltin | 20re/ | un | |
| Sta Registra | ie. | 31. Dete flied (Month 97997) | June Happy | ars Signatu | 16 | | | | | | |



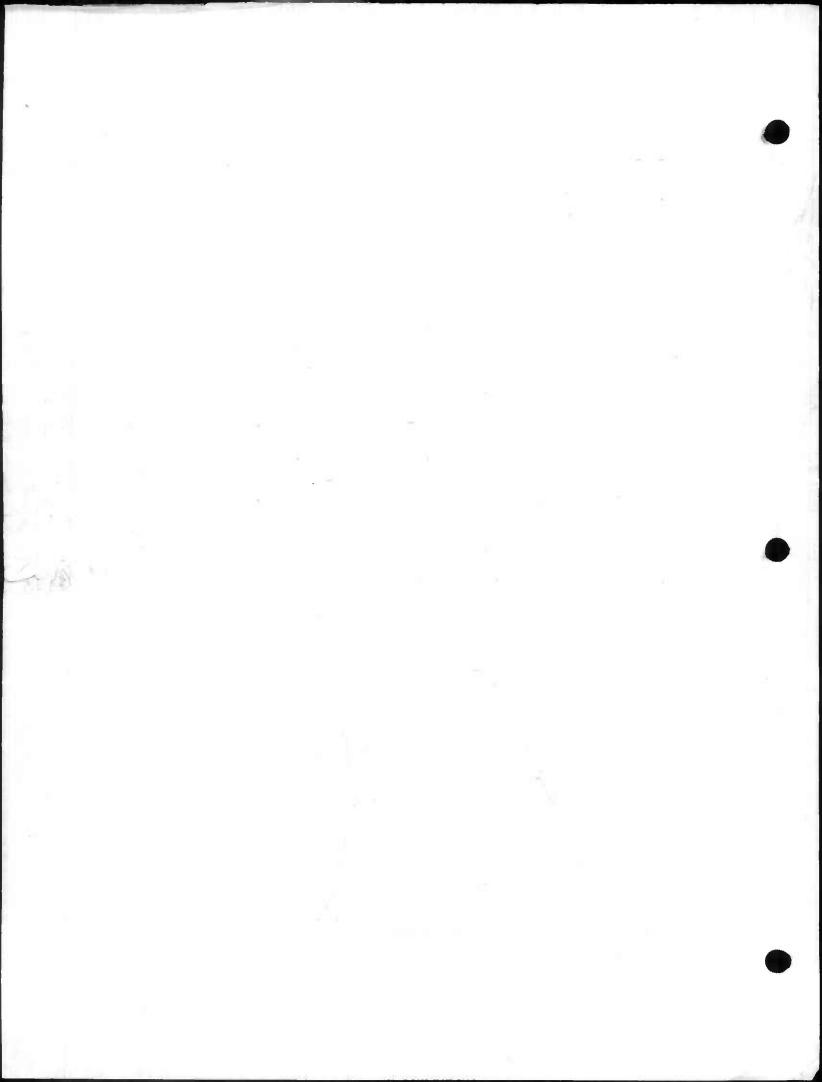
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

| | | 1. DE |
|--|---|--|
| eath. Page 6 may be retained by the hospital or attending physician. Nuneral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should caminer must be notified at once. | TO BE COMPLETED BY FUNERAL DIRECTOR | 11. Ma 2 3 3 11. Ma 1 1 3 2 3 12. S |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 34 from their death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION | 23. IMMN distrease CAU CAU CAU CAU CAU CAU CAU CAU CAU CAU |

| STATE | 0F | MARYLAND | / DEPARTI | MENT OF | HEALTH | AND | MENTAL | HYGI | EN |
|-------|----|----------|-----------|---------|--------|-----|--------|------|----|
| | | | ERTIFIC | CATE | F DEAT | ГН | | REG | NO |

| | 1 - STATE REGISTRAR | STATE OF MARY | LAND / DEPARTI CERTIFIC | | | MENTAL HYGIE | | | | |
|------------------|--|------------------------------|---|-------------------------------|---------------------|---|----------------------|---|--|--|
| | 1. DECEDENT'S HAME (FIRE ACCESS LAND | ho | ckrid | 90 | , | 2. DATE OF DEATH | DAY | SHAP 12 AM | | |
| | 4. SOCIAL SECURITY NUMBER 234-24-3509 BE. FACILITY NAME (V. nor assuration, give | 1 □ M 2 🔘 F | 76 vas. w | UNDER 1 YEAR ONTHS DAYS | HOURS MIN. | | _ | B. BHITHPLACE (Strain or Foreign Country) West Virginia | | |
| TOR | St. Joseph Hosp | | | 70 (| son | | Baltimore | | | |
| . DIRECTOR | Maruland | | 10c. CITY, | TOWN OR LOCAL | | Towson | | 10d. INSIDE CITY LIMITS? 1 □ YES 2XXNO | | |
| FUNERAL | 11. MARITAL STATUS 1 Never Married 2 Merried | 7700 York Ro | R IN U.S. ARMED | 13. WAS DEC | | 21204 NIC ORIGIN? (Specify in, Puerto Rican, atc.) | U | uted States 14. RACE — American Indian, Black, White, stc. | | |
| D BY | 3 Widowed 4 □ Divorced 15. DECEDENT'S ED | IF YES, GIVE WAR OR | DATES 16a. DECEDENT'S US | | 2 NO Specif | | | specify: White | | |
| COMPLETED | (Specify only highest grad Elementary/Secondary (0-12) 10 Yearts | College (1-4 or 5+) | (Give kind of wor life. Do NOT use i | k done during mo retired.) | on st of working | 16b. KIND OF I | un Hon | | | |
| BE | 17. FATHER'S NAME (First, Middle, Last) NOT KNOWN 190. INFORMANT'S NAME (Type/Print) | Landr | | DODESS (Street | | ME (First, Middle, Meld Not Know) Route Number, City or | n | | | |
| 2 | Charles Lockrid | ge/Son | | | | r. Jarri | ttsvi | ele, MD 21084 | | |
| | 20e. METHOD OF DISPOSITION 1X Purier 2 Cremation 3 Re- 4 Donation 5 Other (Specify) | movel from State | cob, PLACE AND DATE OF Competery, crematory or other GALACKS Of | Faith | Cem. 9/ | 6/97 B | altim | One, MD | | |
| 1 | 21. SIGNATURE OF FUNEFIAL SERVICE | 1. Hen | ine | Duda. | -Ruck Fu | EFACILITY Funeral Home of Dundalk, Inc. No. Dundalk, Maryland 21222 | | | | |
| | 23. PART 1. Enter the diseases all ahock, or heart feliure iMMEDIATE CAUSE (Final disease or condition resulting in death) | Let only one cause of | each fine. | ia | | | | Interval Between Onaat and Daath | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | 6. | S A CONSEQUENCE OF): | Tel. | robo 1 | Benz 1 | V250. | war presse | | |
| AL | PART II. Other significant conditions of the state of the | one contributing to death | but not resulting in | the underlyin | g cause given in | PERI | AN AUTOPSY ORMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | |
| PHYSICIAN: MEDIC | DID TOBACCO USE CON | TRIBUTE TO CAUSE | OF DEATH YES | | UNCERTAI | N 🗆 | | 1 NES 2 NO | | |
| YSICI | EXAMINER2 1 VES 2 NO | HOSPITAL: | rutpatient 3 DOA 4 | | | 8 Other (Specify) | | | | |
| BY | 27. MANNER_OP_DEATH 1 Netural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined | 28e PLACE OF INJE | r) INJUI | M 1 🗆 | YES 2 NO | 281. LOCATION (Streetly or Town, St | et and Numbi | er or Rural Route Number, | | |
| COMPLETED | 29s. CERTIFIER (Check only | SICIAN: To the best of my kn | | | | | | ated, | | |
| TO BE CO | 286. BIGNATURE AND TITLE OF CERTIFICATION OF PERSON W | 100 | null | en | Nec. LICENSE MU | | 2000 | , | | |

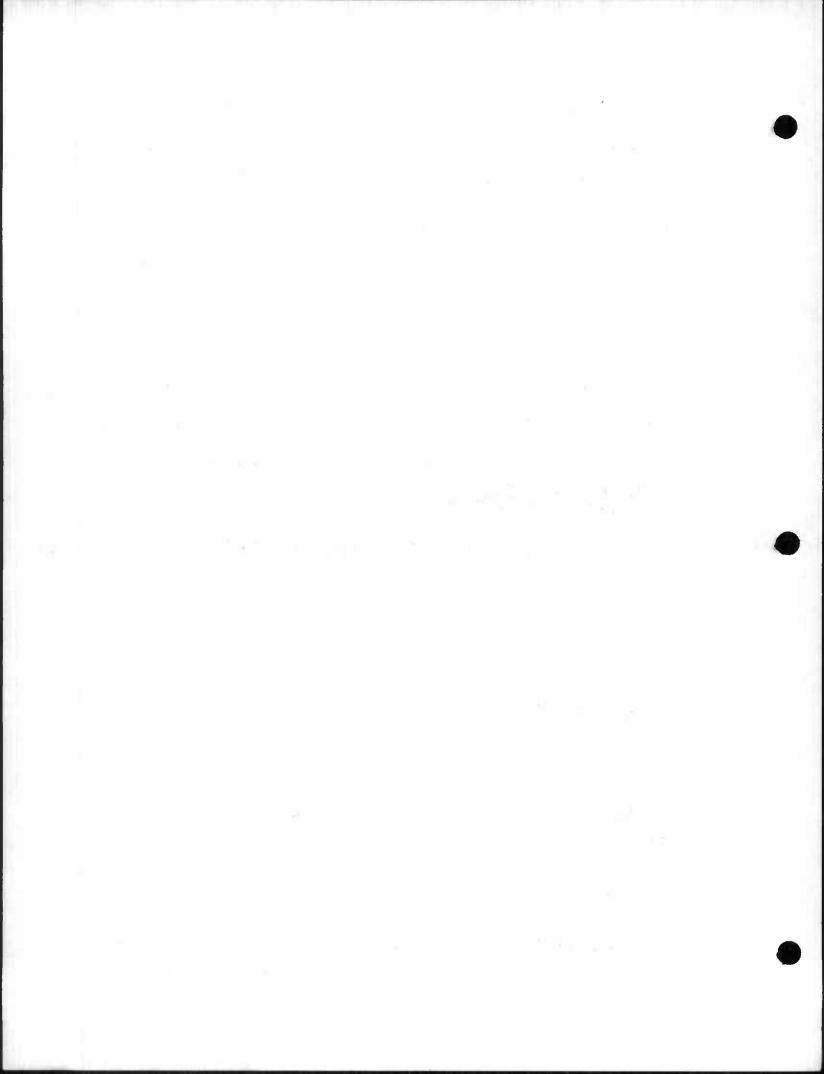


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Yaar Vergie Μ. Lumley 9 5 97 2:45 am /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Rosedale If Under 24 Hrs. 8 Manor Care Health Services Balto County If Under 1 Year 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dev. Year) **Funeral** 1 M 2 F Months Deys Hours Min. Yrs. Director 241-22-3856 Usual Residence of Decedent VIrginia X 82 the Marylend 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 Yas 2 No Director Maryland Baltimore Bowleys Quarters 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 534 Holly Hunt Road 21220 death 12. Wes Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 14. Race - American Indien, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puerto Rican, etc.) permit. Peges 1 and 2 should be filed within 72 hours after to Depertment of Health and Mental Hygiene. Important: If Item 27 is merked other than "natural", or free any injury or other traumatic event 1 ☐ Never Married 2 ☐ Marriad Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ 3K Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th. Grade Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be н. Eanes Julia Α. Mannin 19a, Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) James G. Lumley 534 Baltimore, MD / Son Holly Hunt Rd. 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State XXBurial 2 Cremetion 3 Ramoval from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 9/8/1997 Gardens of Faith Cem. Baltimore, MD 21. Signeture of Funeral 22. Nama end Address of Fecility Dippel Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errast, shock, or heart feilure. List only one cause on each line. 7110 Belair Road Baltimore, MD 21206 Approximete Intervel Between Onset and Deeth **Physician** CARCINOMA WERTPE /Medicai Immediate Cause (Final diseese or condition resulting in deeth) Examiner Examiner buriel-transit Sequentially list conditions, it eny, leading to immediata ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last and Due to (or es a consequence of) Box 68760 8 Physician/Medical the Dua to (or as e consequence of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause givan in Part I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? ANEMIA 1 Yes 2 No 3 Probably 4 Tribnown signed t þ 24b. Were autopsy findings aveilable prior to completion of causa of death? 24a. Was an autopsy performed? Completed certificate 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: "within 24 hours after death." To the Funeral Director: After this certifica 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No Accident in by the 3 Sulcide 6 Could not be determined Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, dete and plece, end due to the ceuse(s) and menner es steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete end place, and due to the ceuse(s) 29e. Certifier Medicai and manner stated. 29b. Signatura and title of conflict 29c. Licanse number 30 Mame end eddress of person who completed cause of deeth (Item e, un zorze CA 8

State Registrar

31. Dete filed (Month, Dey, Year)

SEP



| | _ | 0 | | | ificate of | Health and I | | Reg. No. | 1 2/32/ |
|---|---------------------|--|--|---|---|--|---|------------------------------------|--|
| Physicia /Medica | al | Dacedant's Nama (First, Middle, La Mary Carlotta Facility Name (If not institution on | Larsen | | | 4b. City, Town, or | 2. Date of De Month Sep 7 | Day | Year 97 11: 45 pm |
| Examine | | 4e. Facility Name (If not institution, given Charlestown Number 1987) | | | | Catonsv | | | imore |
| Funeral Director | | 5. Social Security Number 6. S | | last birthdey) | If Under 1 Yes Months Days | If Under 24 Hrs | 8. Date of Bir | v. Year) | 9. Birthplace (State or Foreign Country) Pennsylvania |
| h the Maryland r 28a-f show untiffed at | tor | Usual Residence of Decedent 10a. State 10b. County Maryland Baltir | | y, Town or Loca tonsvi | | | | | 10d. Inside City Limits 1 ☐ Yes 2 No |
| th with the 23e or 28e ust be noti | Direc | 10e. Street and Number 711 Maiden Cho | ice Lane Apt | • | 10f. Zip Code 21228 | | | 10g. Citizen of V United | What Country? States |
| | by Funeral Director | 11. Marital Status 1 □ Naver Married 2 □ Married 3 ☑ Widowad 4 □ Divorcad | 12. Was Decedent Ever in U Armed Forces? 1. ☐ Yas 2 ☐ No If Yes, Give Year or Dates: | if ' | as Decedent of Yes, specify Cu | Hispanle Origin? (S ban, Maxlean, Puarl Specify: | pecify Yes or No to Rican, atc.) | | e - Americen indian, ck, White, etc. |
| | Completed | 15. Decedent's E (Specify only highest gra Elementery/Secondery (0-12) 1 2 | ducetion | 16a. Decede (Give ki life. Do | | upetion e during most of wo ed) | rking | 16b. Kind of Bu | usiness/Industry |
| 名がある | To Be Co | 17. Father's Name (First, Middla, Last, Grant U. Unger | | Caret | ella | 18. Mother's Nar Ada Gar | | | |
| ges 1 and 2 should of the sith and M If them 27 is man or other traumation | | 19a. Informant's Name/Relationship (Patricia Terry) 20e. Method of Disposition | Type, Print) daughter Ramoval from State | 5915 Plece of Disposi cemetery, creme | Oakla ition (Neme of etory or other p | (ace)Park | Arbutu Date 0-12- | s, Mar 20c. Location - | yland 21227 City or Town, Stata |
| permit. Pa Departmen Important: any injury pnce. | | 4 Donation 5 Other (Specifical Service Licerature of Furieral Service Licerature of Furieral Service Licerature (Specifical Service Licerature) | | 13 | Name and Add | | 1997 hbrose bring R | | ice, Pennsylva 1 Home, Inc. |
| Physician /Medical Examiner | Examiner | 23a. Part1. Entar the disaase, or comshock, or heart failure. List only immediate Cause (Finel disease or condition rasulting in death) | a. End Due to (c | 5 tags | e De | mentic | | | Inferval Between Onsat and Death YEGY |
| ficate be physicial is the bur | edical | Sequentially list conditions, if any, leading to immediate ceuse. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last | C | or es e consequ | | | | | |
| of by the etter | Physician/M | Part II. Other eignificent conditions of | ontributing to death but not res | ulting in the und | derlying ceuse (| given in Part I. | | tobacco uee co | ntribute to the cause of death? 3 Probably 4 Unknown |
| been s | Completed by | | | | | | 24e. Wes | en eutopsy ormed? | 24b. Were eutopsy findings available prior to completion of cause of death? |
| ysician: The law is certificate has director, page 2 | Com | | | | | | 10 | Yes 2 No | 1 ☐ Yes 21 No |
| Physician: The | Be | 25. Was cese referred to medical examiner? | Hospitel: | | _ [0 | Whor: | ath (Check only | | |
| Phys rrthis arai di | 1: To | 1 Yes 2 No 27. Mennér of Death | 1 ☐ Inpatiant 2 ☐ 28a. Date of Injury (Month, Dey Year) | ER/Outpatient 28b. Time of | 3□ DOA 28c. Inj | 41 Nursing F | loma 5 ☐ Rasi 28d. Describe | dence 8 □Oth how injury occur | |
| To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral | Certification: | 1 Naturel 5 Pending 2 Accident invastigation 3 Suicide 6 Could not be determined | P Ros Bisso of Laises. At La | Injury ome, farm, stree y) | M 1 | ☐Yes 2☐No | 28f. Location (City or To | Street and Numb wn, State) | per or Rurel Route Number, |
| Hospital of 24 hours of Funeral D etely filled i | edical Ce | 29e. Certifier (Check only one) 1 Certifying Ph | ysician: To the best of my kno ninar: On the besis of examine and manner stated. | wiedge, death o tion end/or inve | occurred at the estigetion, in my | time, dete and place opinion, deeth occu | e, and due to the urred at the time, | ceuse(s) and me dete and place, | enner es steted. and due to the cause(s) |
| To the within 7 To the comple | Me | 29b. Signature and title of certifier | | 10 | | nsa number | | | d (Month, Day, Yaar) |
| 3 | | 30. Name and address of person who | completed ceuse of death (Iter | n 23e) (Type, P | rint) | 5,00 | | 1 | 11/2 |

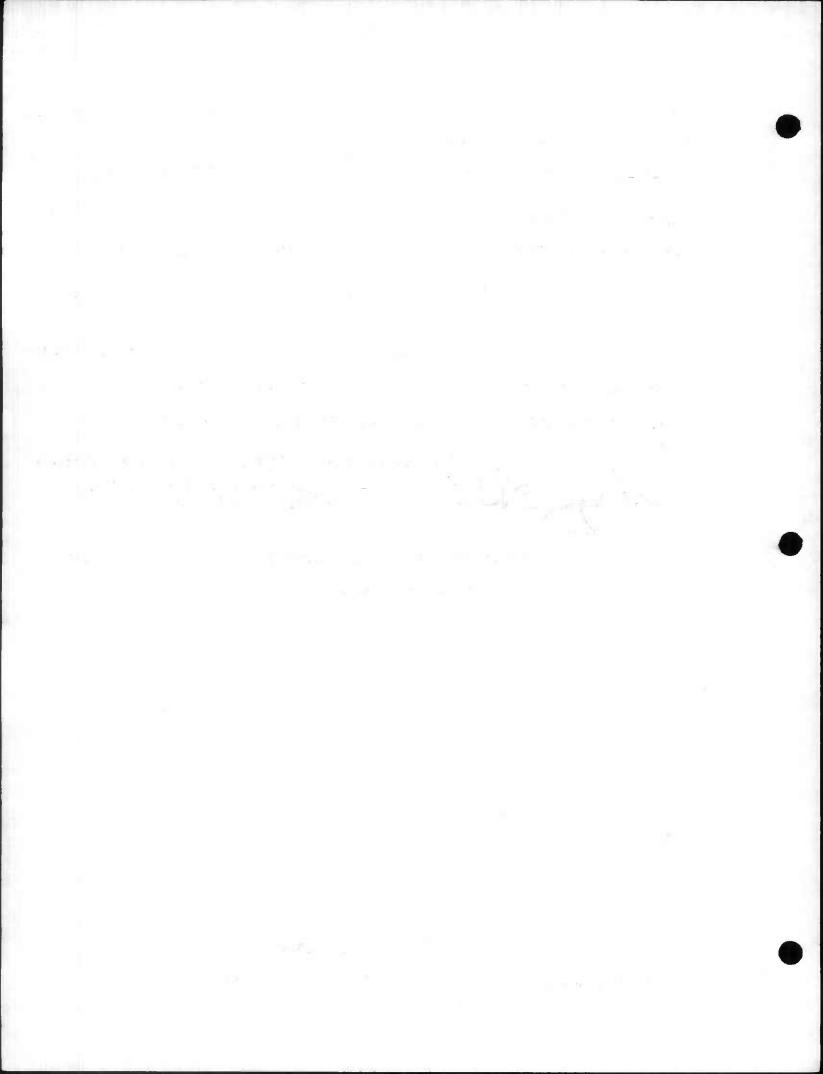
weet I wit.

Telego, Ca

State of Maryland / Department of Health and Mental Hygiene 97 27328

| | | | | | | Cert | tificate | of Death | _ | Reg. No. | 1 6 | . 1020 |
|--|--|--|--|--|---------------------|------------------------------|----------------------------------|--|---------------------------------------|---------------------------------|--|---|
| Dhu | !.!. | | 1. Decedent's Neme (First, Middle, La | est) | | | | | 2. Dete of De | eth | Vana | 3. Time of Dea |
| | /sicia ledica | | George | | | MAV | RIS | | Month | Dey ber 7, | Year 1997 | 3:02 A. |
| | amine | _ | 4e. Fecility Neme (If not institution, given | ve street end number) | | | | 4b. City, Town, or | Location of Deer | | nty of Deeth | J. 02 A. |
| Fune | | | Franklin Square H 5. Sociel Security Number 6. S | | e (In yrs. last | | If Under 1 Y | Rosedale Year If Under 24 Hrs Beys Hours Min | | Balt: | imore 9. Birthpl | lece (Stete or Foi |
| Direc | | | 110-10-4052 Usuel Residence of Decedent | 2 2 | 89 | Yrs. | | | April | 28, 19 | U8 Gr | eece |
| ne Maryla 8a-f shov | Sured at | ctor | Maryland | Baltimore | TOC. City, 1 | own or Loca | ation | Dundalk | | | | 1 Yes 2 |
| ath with the 23a or 2 | 20100 | Funeral Director | 10e. Street end Number 2727 North Point | Road | | | 10f. Zlp Co | 2122 | 2 | 10g. Citizen o | d Stat | • |
| Maryland 21215-0020 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show | - Xalonosa I | þ | 11. Maritel Status 1 □ Never Married 2 ☑ Merried 3 □ Widowed 4 □ Divorced | 12. Was Decedent I Armed Forces? 1 Yes 2 N If Yes, Give Yeer or Detes: | | | es Decedent Yes, specify | of Hispanic Origin? (Cuben, Mexican, Puer No Specify: | Specify Yes or No rto Rican, etc.) | Special | ece - America leck, White, e cify: | |
| 72 h | | Completed | 15. Decadent's E (Specify only highest gre | ducation | 1 | 6e. Decede | ent's Usuel O | ccupetion | ndkina | 16b. Kind of | Business/Ind | ustry |
| F G | | ğ | Elementary/Secondary (0-12) | College (1-4or 5 | +) | life. Do | O NOT use r | one during most of wo etired) | nning . | | | - |
| filed withii Hygiene. other then | | Ö | 4 Years 17. Fether's Neme (First, Middle, Last | | | Owner | | | | | | ng Indus |
| Tal Hall | be filed other dother event, Be Cc | | | | | | | | me (First, Middle | | ame) | |
| Men Men | | 2 | John Michael Ma | | | | | | kevi Tsu | | | |
| Marylan d 2 should be f th and Mental F 7 is marked of | | | 19e. Informent's Neme/Reletionship (| | 1 | | | reet and Number or F | | | | |
| and and m 27 | | - | Mrs. Anna Mavris | /Wife | | | | Point Roa | | | | |
| H ita | 5 | | 20e. Method of Disposition 1XD Burial 2 ☐ Cremetion 3 ☐ | Removel from State | 20b. Plece | e of Disposi etery, creme | ition (Neme of story or other | of r plece) | Dete | 20c. Location | n - City or To | vn, Stete |
| Pag ment | 2 | | 4 □ Donetion 5 □ Other (Specif | | Oak | Lawn | Cemet | ery 9/9/ | 1997 | Balt | imore. | Marylar |
| permit. Pages 1 and 2 Department of Health a Important: If item 27 is | once. | | 21. Signature of Fundinal Service Licer | nsee S | 2 | Du | ıda-Ru | ddress of Fecility Ck Funeral se Ave. D | Home of | Dunda | lk, In | |
| Physici /Medic Examir | cal ner | 16 | 23a. Pert1. Enter the disea or com shock, or heer failury list only Immediate Cause (Finel disease or condition resulting in death) | e. Aortic | | Prost | hesis | Insuffici | | | 2 | Approximele Intervel Between Onset end Deeth Years |
| deeth certificate be executed teatherding physician and official and official and official and the hundrings of the hundrings | | Medic | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that intileted events resulting in death) Lest | c | Value Due to (or es | a conseque | ence of): | : | | | | |
| a deeth the atte | | Physician | Pert II. Other significant conditions of | ontributing to death bu | t not resultin | g in the und | derlying caus | e given in Pert I. | 23b. Did | tobacco use o | contribute to | the cause of de |
| that the ded by | 3 I. | by Phy | | | | | | | 10 | Y00 2 X No | 3 □ Prob | ably 4□Unkı |
| aw requires to should | | Completed | | | | | | | | en eutopsy ormed? | con | re autopsy findin lleble prior to npletion of cause leeth? |
| The la | | | | | | | | | 10 | Yes 2 No | 1 🗆 | Yes 2□ No |
| Jelan: The certificate | 2 6 | g | 25. Wes case referred to medical examiner? | Hospital: | | | | _ | eth (Check only | one) | | |
| Afte Afte | | Pospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing | | | | | | | | dence 6 Co how injury occ | |) |
| al or Attending s efter death. | effer death Director: I in by the ertifical | | 2 Accident investigation 3 Sulcide 6 Could not b 4 Homicide determined | | | , ferm, stree | | | 28f. Location (City or To | | mber or Rural | Route Number, |
| Hospit 24 hour Funeral | Funer Funer Tehy fill | - | | | | | | | | ceuse(s) end i dete end plec | menner as sta a, and dua to | ited. the ceuse(s) |
| To the To the | | | 29b. Signeture end title of cartifier | | | | 29c. Li | cense number | | 29d. Dete sign | ned (Month, E | ley, Year) |
| -> | | | > Sto ILAT | | | • | 1 | RD 01926 | | 9/7/ | 97 | |
| 6 | | | 30. Neme and address of person who | completed cause of de | eth (Item 23 | a) (Type, Pi | | 01720 | | 1/// | 1/ | |
| | | _ | Dr. Sheena Antoni | | | | e Dr. | Baltimore | , Maryla | nd 212 | 37 | |
| | State | e | SEP 0 9 1997 | Gulle, De | r's Signeture | andelle | 4 | | | | | |

DHMH 16 Rev 6/95

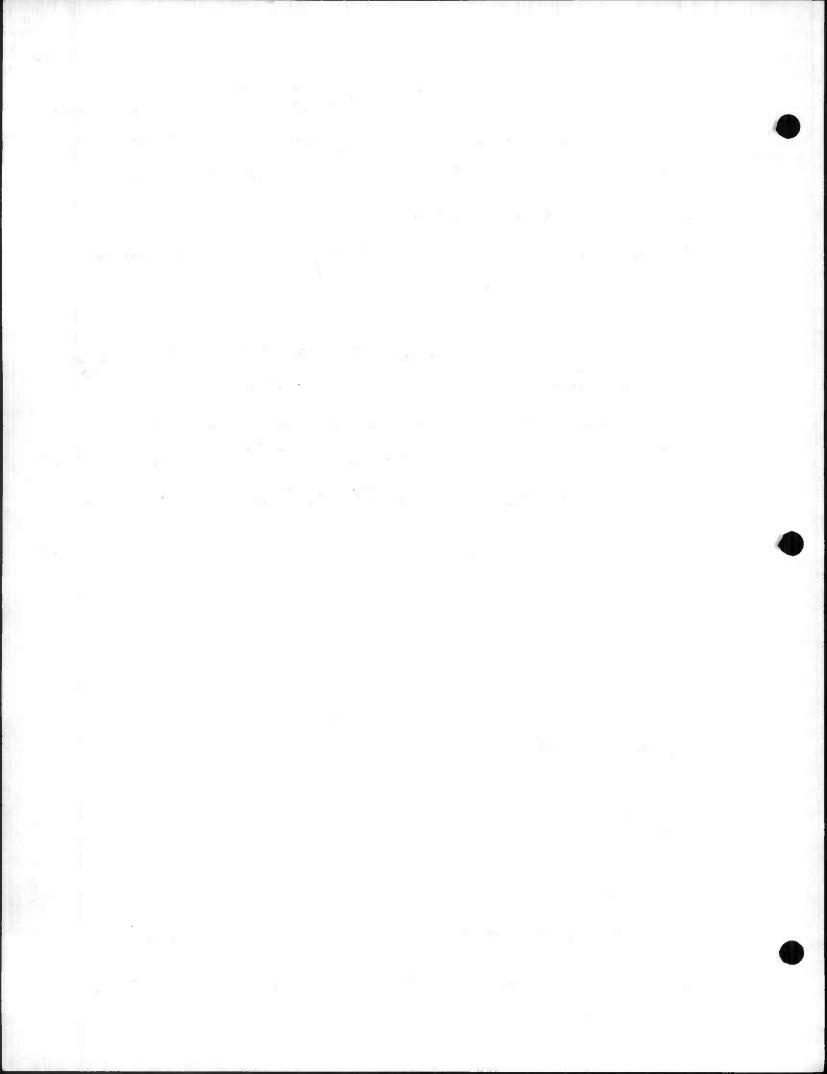


State of Maryland / Department of Health and Mental Hygiene 97 27329

| | | | | | , | Cert | ificate of | Death | , | Reg. No. | , | |
|----------------------------|--|---------------------|--|--|-----------------------|---|--|--|---------------------------------------|------------------------------------|---------------------------------|---|
| | Physic /Medi | | 1. Decedent's Neme (First, Middle, Las Ronald L | ot) | | MCK | erre | 11 | 2. Dete of Domonth SEPTEM | eeth Dey | Yeer 1997 | 3. Time of Deeth |
| 1 | Exami | | 4e. Fecility Neme (If not institution, give THE JOHNS HOPKI | The second secon | AL | | | 4b. City, Town, or BALTIMO | | th 4c. County | | 10.000 |
| | Funeral Director | | 217-40-1387 | ex 7. Ag ⊠M 2□F | e (In yrs. last 55 | birthdey) Yrs. | If Under 1 Yee Months Deys | r If Under 24 Hrs | | rth ey, Year) | 9. Birthpie Countr Maryla | ece (Stete or Foreign y) and |
| | and w | | Usuel Residence of Decedent 10a. Stete 10b. County | | 10c. City, T | own or Loca | ition | | | | 100 | d. Inside City Limits |
| | Maryl 4 sho | ō | Maryland Anne Ar | unde1 | | Burni | | | | | 100 | 1 ☐ Yes 2 ☒ No |
| | h with the | ai Director | 10a. Street and Number 604 Kuethe Rd. | | | | 10f. Zip Code 21060 |) | | 10g. Citizen of V | | |
| 020 | d within 72 hours efter deeth with the Maryland jiene. Than "natural", or Items 23s or 28s-f show the Madical Examiner master profitted as | by Funeral | 11. Maritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Wes Decedent Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Year or Detes: | | | es Decedent of es, specify Cu Yes 2 2 No | Hispenic Orlgin? (S ben, Mexican, Puert Specify: | pecify Yes or No Rican, etc.) | o- 14. Red Ble Specifi | ce - America ck, White, et | tc. |
| Maryland 21215-0020 | within ane. than | Completed | 15. Decedent's Ed (Specify only highest gra Elementery/Secondery (0-12) | ucation de completed) College (1-4or 5 | (+) | (Give kii life. DC | | upation e during most of wor ed) County I | | 16b. Kind at B | | istry |
| p | e liled other vent, p | BeC | 17. Fether's Neme (First, Middle, Last) | | | | | T | | e, Maiden Surnan | | |
| /lar | should be nd Mental marked o | To B | George S. McKerre | 11 | | | | Dora Con | rea | | | |
| lan | 0 0 0 2 | | 19e. Intorment's Neme/Relationship (7 | ype, Print) | 1 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zij | | | | | State, Zip C | 2ode) |
| | 1 and 2 Health am 27 i | | Mary E. McKerrell | / Wife | | | | d., Glen I | 7 5 5 5 5 5 | | | |
| Baltimore, | pemit. Pages 1 an Department of Heal Important: If Itam 2 any injury or other once. | | 20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ | | | | ion (Name of tory or other pl | ~ F | t. 10, | 20c. Location - | | |
| 語 | artme artme ortant injury | | 4 □ Donetion 5 □ Other (Specify 21. Signeture of Funeral Service Scen | | Glen | - | n Mem. | | 1997 | Glen Bu | ırnie, | Maryland |
| Ba | Depa impo any ii | | Top a 2 | لمنت | | Ki: | rkley-R | uddick Fu Hwy., S. | neral H E., Gle | ome, P.A | A. e, MD | 21061 |
| | Physician /Medicai Examiner | | 23e. Part 1. Enter the disease, or comp shock, or heart teiture. List only of immediate Cause (Final disease or condition resulting in death) | e. SCPS | | | | ring, such es cardiad | c or respiretory e | errest, | | Approximete Interval Between Onset end Deeth days |
| Box 68760, | eath certificate be executed ettending physician end for use es the buriel-transit | ın/Medicai Examiner | Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest | c | Due to (or es | | | | | | | 1 40 |
| | 0 0 2 | Physician/ | Part II. Other aignificant conditions co | entributing to death b | ut not resulting | g in the und | erlying cause g | iven in Pert I. | 23b. Did | tobacco uee co | ntribute to t | the cause of death? |
| s, P.O. | requires that the death | by Phy | Chronic obs | tructive | puli | none | ary o | lise asc | 1 🗆 | Yes 2 No | 3 ☐ Probe | ably 4 Unknown |
| Secord | 2 s c | Completed | renal failu | re | | | | | 24e. Wes | s en autopsy ormed? | com | e eutopsy findings lable prior to pletion ot cause eath? |
| a | certificate h | | | | | | | | 10 | Yes 200 No | 1 🗆 | Yes 2□ No |
| Ĭ | siciar certif irecto | o Be | 25. Was case reterred to medical exeminer? 1 ☐ Yes ②☑ No | Hospitel: | | | -5-0 | 26. Plece of Dee | | | | |
| 0 | g Phys er this eral d | - | 27. Menner of Deeth | 28e. Dete ot inju (Month, Day | v 281 | Outpetient b. Time of Injury | 3□ DOA 28c. Inju | | | idence 6 Oth how injury occur | | |
| Division of Vital Records, | or Attending Is siter death. Director: After in by the funer ertification. | | Neturei 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | Yes 2 No | | (Street end Numb wn, Stete) | per or Rural I | Route Number, | | | | |
| | To the Hospital within 24 hours of the Funeral completely filled | edicai 0 | 29e. Certifier (Check only one) Certifying Phy | rsician: To the best of iner: On the besis of end menner sta | examinetion | dge, deeth o end/or inves | ccurred et the t stigetion, in my | time, dete end plece opinion, death occu | , end due to the rred et the time, | cause(s) end me dete end plece, | enner es stat and due to t | ted. he cause(s) |
| | /- | M | 29b. Signature and title of confider | er M. | D. | | 0 | ise number | 0 | 29d. Date signe | 100 | |
| | 12 | | 30. Neme and eddress of person who of Tower 110, 600 | ompleted cause of d | eeth (Item 23) | e) (Type, Pr | et, Jo | ohns Hopk | ins Ho | pital, F | Balti | noe |
| | Sta | te | 31. Dete tiled (Month, Day, Year) | 32. Registra | ar's Signeture | - | | | | MID, C | - 1 | , |

Julia Savidor-Randesse

DHMH 16 Rev 6/95



| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 show be filed within 72 hours after death with the State Deor, of Heath and Mental Hydiene prior to burial. cremation, or removal | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified |
|---|---|---|
| o pe | age. | be |
| 6 ma | ctor, | must |
| Page | al dire | ner |
| death. | funer | шех |
| after | y the | cale |
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| withir | TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the fu be filed within 72 hours after death with the State Dear, or Health and Mental Hotiene prior to burial cremation, or removal | vent, |
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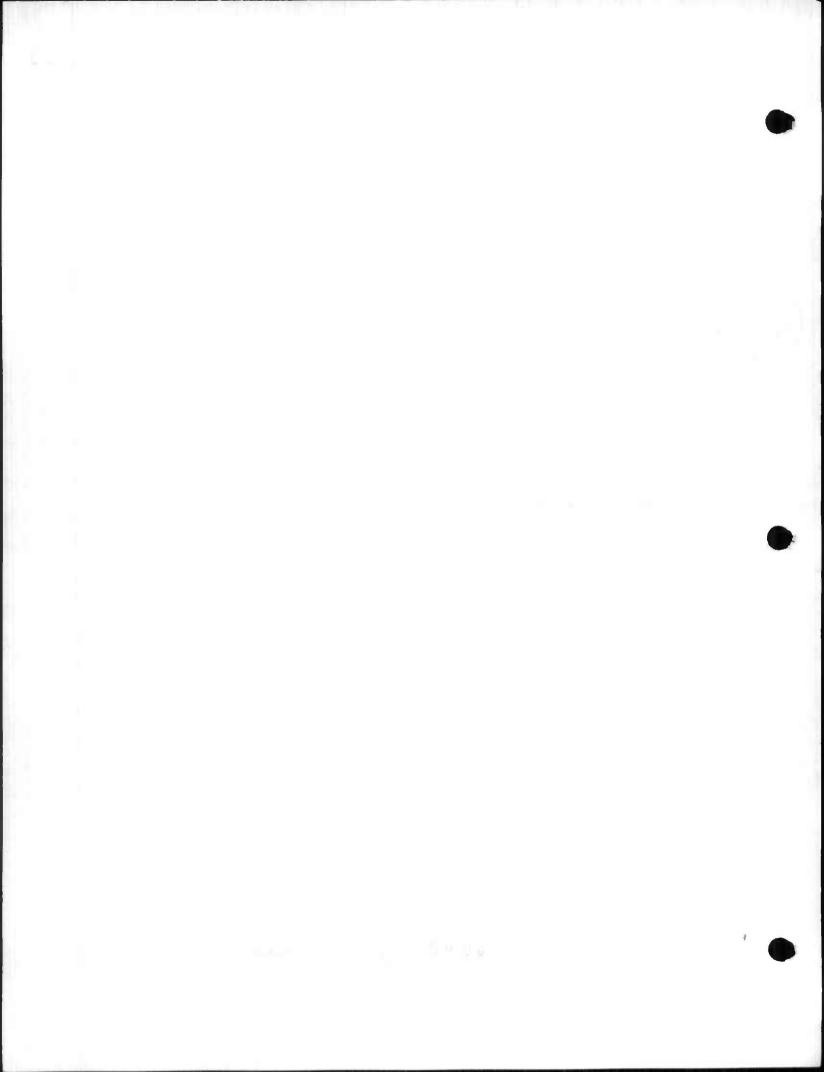
| | FOR | | | | | | | |
|---------------|---|---|------------------------------------|-----------------------|---------------------------------------|--|----------------------|--|
| | 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPAR CERTIF | TMENT OF ICATE OF | HEALTH AND DEATH | MENTAL HYGII | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATN | ein: | 3. TIME OF DEATH |
| | | sie Marti | n | | | Sept. 4 | , 199 | 4:50 PMm |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7 DATE OF BIOTH | | L BIRTNPLACE (State or Foreign |
| | 215-22-9491 | | 9 YRS. | MONTHS DAYS | HOURS MIN. | Dec. 4 | 1917 | Country) North |
| | 9e. FACILITY NAME (If not institution, give s | | | 9b. CITY, TOWN | OR LOCATION OF D | | | Y OF DEATH |
| l e | Carroll Co. Ge | eneral Hosp | ital | West | tminste | r | Car | roll |
| 5 | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT | v | | | | | | |
| DIRECTOR | 105.00011 | arroll | 10c. CIT | Y, TOWN OR LOC | inster | | | 10d. INSIDE CITY LIMITS? |
| | 100. STREET AND NUMBER | alloll | | | | | | 1 TES 2 X NO |
| FUNERAL | 3417 Farmstead | Drive | | , | 21157 | | | ed States |
| S | 11. MARITAL STATUS | 12. WAS DECEDENT EVER | N U.S. ARMED | 13. WAS DE | CENDENT OF NISPA | NIC ORIGIN? (Specify | Yes or No — 1 | 4. RACE — American Indian, |
| BY F | 1 Never Married 2 Merried 3 Wildowed 4 Divorced | FORCES? 1 YES | | | pecify Cuben, Mexic S 2 X NO Speci | an, Puerto Rican, atc.) fy: | | Black, White, atc. Specify: |
| 1 | A | | | | 26.70. | | | White |
| H | 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | 18e. DECEDENT'S (Give kind of v | vork done during a | ION lost of working | 16b. KIND OF | BUSINESS/INDUS | STRY |
| 1 | Elementary/Secondary (0-12) | College (1-4 or 5+) | Ille. Do NOT us | e retired.) | | | | |
| COMPLETED | / | | Button | Marke | | | | cturing |
| | 17. FATNER'S NAME (First, Middle, Last) AMOS | Dorry | | | Mart | AME (First, Middle, Maio | | |
| B | 190. INFORMANT'S NAME (Type/Print) | Perry | | | | | Roark | |
| 2 | Nancy Binder | Daughter | | | end Number or Aural ead Dri | Route Number, City or 1 | | er, Md 21157 |
| | 20a METHOD OF DISPOSITION | | | | | | | |
| | 110 Buriel 2 Cremation 3 Rem | oval from State cen | PLACE AND DATE Of of of | her place! A 7 0 | n Rant | | | ty or Town, State |
| | 21. SIGNATURE OF CONERAL SERVICE LIC | | Church | cemete | ry - | 9/10 KO | nnoroc | k Virginia |
| | | | | 1328 | Sull nh | Ambro | se Fun | eral Home, In |
| <u></u> | | an | | Arbu | tus, Ma | r Sprin | 21227 | , |
| | 23. PART I. Enter the disesses, or shock, or heart fellure. | pmplications that cause List only one cause on a | d the death. Do n | ot enter ths m | ode of dying, suc | ch as cerdiac or res | spiratory stres | |
| | IMMEDIATE CAUSE (Finel | AND THE PROPERTY AND | | | | | | Interval Batween Onset and Death |
| | disease or condition resulting in death) | a. CONGES | TIVE | HEAR: | T FA | ILURG | | |
| | | | | • | | | | |
| NO | Sequantially list conditions, | a SEPSI | CONSEQUENCE OF | | | | | |
| ATI | If any, leading to immediate cause, Enter UNDERLYING | DUE TO (OR AS A | CONSEQUENCE OF | 7): | | | | |
| CERTIFICATION | CAUSE (Disease or Injury | C. DUE TO (OR AS | CONSEQUENCE OF | | | | | |
| Ē | that initiated events resulting in death) LAST | DOC 10 (011 NO 1 | CONSEQUENCE OF |). | | | | |
| CEI | | d | | | | | | |
| AL. | PART il. Other significent condition | a contributing to death b | ut not resulting i | n the undarlyin | ig ceuse given in | Part I. 24s. WAS | AN AUTOPSY ORMED? | 24b. WERE AUTOPSY FINDINGS |
| MEDICAL | | | | | | 1 [] YES | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| E E | | | | | | | | 1 TES 2 NO |
| ž | | | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | LACE OF DEATH (C | neck anly one) | | |
| YSI | 1 ☐ YES 2 → NO | 1 Sumpetient 2 ER/Outp | effent 3 DOA | OTHER: 4 Nursing Hor | ne 5 🗆 Reeldence | 8 Other (Specify) | | |
| 표 | 27. MANNER OF DEATH 1 Patural 5 Pending | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME | E OF 28c. IN | JURY AT | 28d. DESCRIBE NOV | V INJURY OCCUP | RED |
| B | 1 Natural 5 Pending 2 Accident Investigation | | | | YES 2 NO | | | |
| ED | 3 Suicide 8 Could not be | 28e. PLACE OF INJURY building, etc. (Spec | — At home, ferm, s | treet, factory, offi | 20 | 281. LOCATION (Street City or Town, Sta | et and Number or | Rural Route Number, |
| E | | | | | | | | |
| 립 | 29e. CERTIFIER 1 CERTIFYING PNYSH | CIAN: To the best of my know | ledge, death occurre | d at the time, date | e end place, end due | to the cause(e) end n | enner as stated. | |
| COMPLET | one) 2 MEDICAL EXAMINE | R: On the basis of examination | end/or investigation | n, in my opinion, | death occured at the | time, date end place, | end due to the c | Cause(s) end menner ee stated. |
| ш | 29b. SIGNATURE AND TITLE OF CERTIFIER | 111 | | | 29c. LICENSE NU | MBER | 29d. DATE S | HGNED (Month, Day, Year) |
| 0 8 | Namman / | elalu: MD | | | M 35 | 327 | 19 | 14/95 |
| 유 | 30. NAME AND ADDRESS OF PERSON WIN | | | Print) 200 | | al Drive | | |
| | C C GH/Namma | n Halahi | M D | | | | | 01155 |

Julia Savidson-Randall

SEP 0 9 1997

31. DATE FILED (Month, Day, Year)

c.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0.7

| | | | | | | | | - | | Death | | Reg. No. | 91 | | 331 |
|--------------------------------------|--|-----------------|---|--------------------------------------|--|-------------------------------|------------------|--------------------------------------|------------------------|--|--|----------------------|--|--|----------------------------------|
| | Physici | an | Decedent's Name (First, I | | | | | D | | | 2. Date of D Month | Day | | | ne of Death |
| | /Medi | | John | | mond | | MILLE | R | | | | | 4,1997 | | 00 P.M. |
| A | Examir | ier | 4a. Facility Name (If not insti | | | | | | | 4b. City, Town, or | | | County of Dea | | |
| - | | | Franklin Squ 5. Social Security Number | are l | _ | | | (aut) If I In | dar 1 Year | Rosedale | | | ltimor | | -0.5 |
| | uneral irector | | 214 44 4248 Usual Residence of Deceder | 1 [| XM 2□ F | Aga (In yrs. | | Mont | | Hours Min. | | ay. Year) | 945 Wes | ountry) St Vil | rginia |
| the Maryland | show st.at | J. | 10a. State 10b. Co | unty | _ | | ty, Town o | r Location | | | | | | | de City Limits |
| 2 | 28a-f shon | ecto | 4 | timor | e | E | ssex | | | | | | | | Yes 2 No |
| A | Sale. | Funeral Directo | 10e. Street and Number 1026 Foxchase | Lane | | | | 10f. | Zip Code 212 | 221 | | 10g. Citi | zan of What Co USA | ountry? | |
| 050 N | | by | 11. Marital Status 1 □ Navar Married 2 🗗 3 □ Widowed 4 □ Divo | | 12. Was Decede Armed Force 1 Dyes 2 If Yes, Give Year or Date | 2 | ı,s. | | cedent of Figerity Cub | dispanic Origin? (S an, Mexican, Puer Specify: | Specify Yes or N to Rican, etc.) | 0- | 14. Race - Ame Black, Whi Specify: | | an, |
| Maryland 21215-0 | then 'netur he Medical | Completed | 15. Dec (Specify only h Elementery/Secondary (0- | | cation | | 16a. De | ecedent's Unive kind of le. DO NO | | pation during most of wo d) | rking | | nd of Business | | |
| D D | d other event, I | CC | 17. Fether's Neme (First, Mid | dle, Last) | | | | 1100100 | , | 18. Mother's Na | me (First, Middle | | | 450 | |
| ylan Merti | | To Be | Calvin Jam | | Miller | | | | | Juanita | a Be | all | | | |
| Mar and 2 sho | 2 2 | | 19a. Informant's Name/Reia Cynthia Mille | | rpe, Print) Wife) | | | | | and Number or Rie Lane E | ural Route Numi ESSEX, M | | | | |
| Baltimore, | 質り | | 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Crema: 4 ☐ Donation 5 ☐ Other | | | ite | cemetery, | | or other pla | ory 9/6/1 | Date 997 | | cation - City or | | |
| Balti Semit. | mportant: If any injury or once. | | 21. Signatura of Funeral Ser | | | (| \wedge | 22. Name | and Addre | ess of Facility | | | | | |
| | | | 020 | 13 | 2 | | | 1407 | Old I | Eastern A | ve Esse | x, Ma | aryland | | |
| | sician edicai | | 23a. Part1 Ener the diseas hock or leart failure. | List only o | ne dause on each | h line. | in. Do not | enter the n | node ot dyli | ng, such es cardia | c or respiratory | arrest, | | Approx Interva Onsat | imete Il Between and Death |
| | miner | | disease or condition resulting in deeth) | 03 | Syncop | | or as a cor | sequence | of): | | | | | 30 m | inutes |
| D | .= | ner | | | Severe | | | | | athy | | | | | |
| 68760, ificate be executed | physician and the burial-transit | Examiner | Sequentially list conditions, if any, leeding to immediate | | J. ———— | Due to (| or as a cor | sequenca | of): | , | | | | | |
| 68760, ificate be ex | sician buria | SalE | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | ~ | Corona | | | | | | | | | | |
| | 0 6 | /Medical | resulting in death) Last | l, | d | Due to (d | or as a con | sequenca (| ory: | | | | | | |
| Box eath cert | attendin for use | cian | | | | | | | | | | | | 1 | |
| ords, P.O. Box | ed by the attendin detached for use | Physician/M | Part II. Other significant con | ditions cor | ntributing to death | n but not ras | ulting in th | e un derlyin | g cause giv | /an in Part I. | | | use contribute □ No 3 □ P | | use of death? |
| ds, | 5.0 | d by | | | | | | | | | Ode Me | | 246 | Ware suto | psy findings |
| e ec | 2 shoul | Completed | | | | | | | | | perf | s en eutop ormed? | , | available p completion of death? | prior to |
| E E | is certificate ha director, page | | | | | | | | | | 10 | Yes 25 | ₹ No | 1 ☐ Yes | 2□ No |
| Vit | certificate rector, pag | Be | 25. Wes case referred to me examiner? | - | lospital: | | | | Oth | 26. Place of De | ath (Check only | one) | | | |
| on of Vital | 는 현 | lon: To | 1 ☐ Yes 2 ☒ No 27. Manner of Deeth 1 ☒ Natural 5 ☐ Pe | nding | 1 ∐ inpa | | 28b. Tim Inju | e of | 28c. inju | y at rk? | lome 5 ☐ Res 28d. Describe | | | ecify) | |
| Division or Attending | in by the | Certification: | 3 ☐ Sulcide 6 ☐ Co | estigation uid not be termined | 28e. Place of building, | Injury - At h etc. (Specil | ome, farm | M street, fac | | Yes 2 □ No | | (Street and | d Number or R | lu <i>ral R</i> outa | Number, |
| To the Hospital of within 24 hours a | Funeral tely filled | edical C | (Uneck only 2 Med | fying Phys | ner : On the basis | s of exemine | wiedge, d | eath occurr | ed at tha ti | ma, date and place | e, and dua to the urred at the time | cause(s) | and manner a | s stated. | use(s) |
| To the I | To the comple | Med | one) 29b. Signature and filte of on | | and manner | stated. | 0 (| | 29c. Licans | | | | e signed (Mon | | |
| | | | > Leco | ora | MA | ope | no | 7 | D 5 | 1692 | | Septe | ember 4 | , 199 | 7 |
| 5 | 41 | Î | 30. Name and address of per | | | | | | | n 1 . 1 | | | | | |
| | | | Dr. Deborah I | iopkii | 15 9000 | Fran | Klin | Squar | e Dr. | Baltimo | re, Mar | yland | 1 21237 | | |
| | Sta Registr | ie ar | SEP 0 9 199 | T' = 0 | J De la constantina della constantina della constantina della constantina della constantina della constantina della constantina della constantina della constantina della constantina della constantina della constantina della constantina della constantina della constantina della constantina della constantina della constantina della constantina della constantina della cons | onai a diyAt | | | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth

Physician /Medical Examiner

Funeral Director

r 28a-f show chotified at Examiner must be r

215-0020

Baltimore.

Physician /Medical Examiner

certificate be executed pue physician s the burial P.O. Box 68760. signed by i Records,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

Division of Vital

1. Decedent's Neme (First, Middle, Last) 5 50 Month SONDRA NATHAN SEPTEMBER 03 1997 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death | 7. Age (In yrs. last birthday) | If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | Months | Deys | Hours | Min. | (Month, Day, Year) | 190 SINAI HOSPITAL OF 5. Sociel Security Number 6. Sex Birthplace (State or Foreign Country) 1 M 250F 216-28-1990 Usuel Residence of Decedent OCT. 3, 1931 MARYLAND 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD BALTIMORE BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Funeral 6903 JONES VIEW DRIVE U.S.A.

14. Reca - American Indien,
Bieck, White, etc. 21209 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married XX Married 1 ☐ Yes 2 ☐No It Yes, Give Yeer or Detes: 1 ☐ Yes XXNo Specify: þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind ot Business/Industry Eiamantary/Secondery (0-12) College (1-4or 5+) 12 DATA ENTRY SOCIAL SECURITY ADMIN 17. Fethar's Name (First, Middle, Last) 18. Mother's Neme (First, Middla, Maiden Sumame) Be ALLAN BENDER KATTE **GOLDBERG** 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) DONALD NATHAN / HUSBAND 6903 JONES VIEW DRIVE BALTIMORE, MD 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Burial 2 Cremetion 3 Removal from Stete CHIZUK AMUNO ARLINGTON 9/5/97 BALTIMORE, MD 21. Signeture of Funeral Service Ligenses 22. Name end Address of Fecility Sol Levinson & Bros., Inc. 8900 Reiserstown Road Pikesville, MD 21208 on that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, arture on each line. Enter the disease, or comp or heart teilure. List only Approximete Intarvei Batween Onset end Deeth Immediate Ceuse (Finel a. LUNG CANCER.

Dua to (or es e consequanca ot): diseese or condition resulting in daath) ORONARY ARTERY Sequantially list conditions, if any, leading to immediate causa. Entar Underlying Causa (Diseese or Injury that initiated events rasulting in deeth) Lest Dua to (or es e consequenca of): Physician/Medical Due to (or es e consequence ot) Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara eutopsy tindings aveileble prior to 24e. Wes en eutopsy performed? Completed completion of cause of daeth? 25. Wes case reterred to medical Be 26. Placa of Death (Check only one) exeminer? Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 28c. Injury et Work? 27. Manner of Deeth 28b. Time of Certification: 28d. Dascribe how Injury occurred 1 Neturei 2 ☐ Accidant 5 Pending invastigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At homa, tarm, straet, tectory, offica building, etc. (Spacify) 4 Homicida Medicai Certifying Physicien: To tha best of my knowledga, deeth occurred et tha tima, data and place, and dua to tha causa(s) and menner as stated.

2 Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete end pleca, and dua to the cause(s) end menner stated. 29e. Certifier (Check only one)

29c. License number

SINAL HOSPITAL OF BALTIMORE MD 21215

29d. Date signed (Month, Dey, Year)

AS 2402321 JW 9022 SEPTEMBER 03, 1997

State Registrar

31. Dete filed (Month, Day, Year) SEP 0 9 1997

JOHN VAN WU, MD

29b. Signeture end title of certifier

32. Registrer's Signeture Luka Davidson-Randall

30. Neme en addrass of person who complated causa ot death (Itam 23e) (Type, Print)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 8 ames 20 4e. Facility Name (If not Institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Deeth Greenspring Nursing & Rehab. Center Baltimoree Baltimore City ## Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Ye June 29, 5. Social Security Number 7. Age (In yrs. last birthdey) 6. Sex 9. Birthplece (Stete or Foreign Year) Months 1₩ M 2□ F 220-24-0957 Yrs 1929 unknown Usuel Residence of Decedent 10e State 10h County 10c. City. Town or Location 10d. inside City Limits Maryland Baltimore Randalstown 1 Tyes 20No 10g. Citizen of Whet Country? U.S.A. 10e. Street and Number 10f. Zip Code 7 Albess Court 21133 12. Wes Decedent Ever in U.S. Armed Forces? unkno Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian, Bleck, White, etc. 11. Meritel Stetus unknown -sined Forces? unknown 1 ☐ Never Merried 2 ☐ Married If Yes, Give Yeer or Detes 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) unknown unknown 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 808 Ivydale Avenue, Reisterstown, Maryland 21136 Lynn Nickles/daughter 20b. Pieca of Disposition (Neme of 20e Method of Disposition 20c. Location - City or Town, Stete cemetery, cremetory or other place) 1 ☐ Burlei 2 ☐ Cremetion 3 ☐ Removei from State 4 ☐ Donetion 5 ☑ Other (Specify) in state Ponald S. Wade ²² Name end Address of Fecility State Anatomy Board, 655 W. Baltimore Street Nirector Baltimore, Maryland 21201 Baltimore, Maryland 21201 Baltimore, Maryland 21201 Baltimore, Maryland 21201 Baltimore, Maryland 21201 Baltimore, Maryland 21201 Approximete Intervel Between Onset end Deeth Immediate Cause (Finel IPROGRESSIVE FAILURE disease or condition resulting in deeth) Due to (or es é consequence of): Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No ASPIRATION PNEUMONIA 24b. Were autopsy findings evailable prior to completion of cause of deeth? DIABORES MULLITUS, PORIPHURAL VASCULAR DISMAC 24a. Wes en eutopsy performed? 1 Yes 2 No EREBROVASCULAR DISEASE 1 Yes 25. Wes case referred to medical exeminer? 26. Place of Deeth Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Examir Sequentielly list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Physician/Medical

Physician

/Medical

Examiner

Funeral

Director

rai", or items 23a or 28a-f show Examiner must be notified at

"netural", or

permit. Pages 1 and 2 should be filed within 72 ht. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturn any injury or other traumatic event, the Medical in once.

Physician /Medical

Examiner

Director

Funeral

Completed by

Be

2

the Maryland

death

Saltimore, Maryland 21215-0020

Box 68760

P.O.

Vital Records,

Division of

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

27. Menner of Deeth 5 Pending Investigation Naturel

2 Accident 3 ☐ Sulcide 4 Homicide

SEP 0 8 1997

6 Could not be determined

Hospitel: 1 | Inpatient 2 | ER/Outpetlent 3 | DOA 28e. Dete of Injury (Month, Pay Year) 28b. Time of

1 32 Degistrer's Signature

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work?

28f. Location (Street end Number or Rural Route Number, City or Town, State) Certifying Phyelclan: To the best of my knowledge, deeth occurred et the time, dete end pleca, and due to the ceuse(s) end manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete and pleca, and due to the cause(s) end menner stated.

29b. Signature and title of certifier

29c. License number 7 2 5

29d. Date signed (Month, Dey, Year)

of deeth (Item 23e) (Type, Print)

PARK HEIGHTS AVE

28d. Describe how injury occurred

State Registrar

2

Certification:

Medical

29e. Certifier (Check only one)

결

Attac Attending

after death Director:

To the Hospital within 24 hours a To the Funeral E

8

E

| hm TAP AR | NLEY SA | NG | HYUN | | | | / Depa | | Health and | Mental Hy | /giene Reg. No | 97 | 273 | 334 |
|------------------------------------|---|------------------|--|---|--|-----------------------------|--|------------------------------|---|-------------------------------------|--------------------------------|---------------------------|--|--------------------------|
| п | Physic | ian | | | | | | | 2. Dete of Deeth Month AUGUST 31,1997 | | | of Deeth | | |
| a | /Medi | cal | | | | | | | | | | | B PM | |
| 1 | Examine | ner | 10740 LITTLE PATUXENT Parkway Columbia HO | | | | | | County of Deeth IOWARD | | | | | |
| | Funerai Director | | 5. Sociel Security Number 084-72-1587 | 6. Se | ex 7. Ag | ge (In yrs. lest 26 | birthdey) Yrs. | If Under 1 Yes Months Dey | | (Month, D | irth ay, Year 6 19 | 9. E | Birthplece (Stete Country) PPEA | or Foreign |
| | D . | | Usuei Rasidence of Decedent 10a. Stete 10b. Cour | nh (| | 10a City T | aum ar t a | antion | | | | | | |
| | aryla sho | 2 | | | | 10c. City, Town or Location | | | | | | 10d. Inside | | |
| ₽ | N of the second | Funeral Director | | aru | Columbia | | | | | | 1016 | s 200 No | | |
| | \$ 6 th | Dire | 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Co | | | | | | | | Country? | | | |
| | 23a | 100 | 12130-I Lit | 12130-I Little Patux | | | ent Parkway 21044 | | | | U.S | S.A. | | |
| | ep . | ine | 11. Maritel Status 1 ☐ Never Married 257 Married | | 12. Wes Decedent Ever in U. Armed Forces? 197es 2 \(\text{No}\) No If Yes, Give Year or Datas 1 - 97 | | if Yes, specify Cubar | | f Hispanic Origin? (5 | Hispanic Origin? (Specify Yes or No | | 14. Rece - Al Bleck, W | merican Indien, | |
| 0 | afte or it | | | | | | | | | | Specify | | Asian | |
| 21215-0020 d within 72 hours af | ours | Be Completed by | 3 ☐ Widowed 4 ☐ Divord | | | | | | | | | | | |
| 5-0 | d 2 should be filed within 72 hours efter death with the Marylan th and Mentel Hygiene. 7 is marked other than "patural", or items 23s or 28s4 show traumatic avent, the Medical Examiner must be notified as | | 15. Deced | 15. Decedent's Education (Specify only highast grade completed | | | 16e. Decedant's Usuel Occupetion (Give kind of work done during most of work lifa. DO NOT use retired) | | | rkina | 16b. Kind of Business/Industry | | | |
| 7 0 | ighin | | Elementery/Secondery (0-12 | | Collega (1-4or 5+) | | | | | | | | | |
| | filed with! Hygiene. other than | | | | 4 | | Mil | itary | | | | S. Na | vy | |
| pu | T do t | | 17. Fether's Neme (First, Midd | lie, Last) | | | | | 18. Mothar's Na | ma (First, Middle | e, Maidar | Sumama) | | |
| yla | Men Men arke | To | Soon Young | Parl | k | | | | Ryang | Sook 1 | Han | | | |
| lar | 2 should be fi end Mentel It is marked of reumatic aver | | 19e. Informent's Neme/Reletionship (Type, Pnnt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 2 1 0 4 | | | | | | | | | | | |
| | Heelth Fire 27 I | | Dabet M. Pa | rk/ | Wife | | 1213 | 0-I Li | ttle Pa | tuxent | Par | kway, | Colum | nbia |
| Baltimore, | permit. Peges 1 end Department of Heelth Important: If Item 27 eny injury or other fr once. | | 1 Ma Burial 2 Cremetic 4 Donetion 5 Other 21. Signeture of Funeral Servi | (Specify | (hend) | Arl | Ha 12 | Ridge | ress of Fecility Funeral Ly Aven | ue, Ani | , P. | Α. | MD 214 | 101 |
| > | Physician /Medical Examiner | | 23a. Pert1. Enter the diseale, shock, or heart fellure. I immediate Cause (Final disease or condition resulting in death) | or comp ist only o | olicetions that cause one ceuse on each li | d the death. Dine. | o not ente | er the mode of d | ying, such es cardia | c or respiretory | errest, | | Approxima Intervel Be Onset end | ate etween i Death |
| | | | | | 3 | Due to (or as | consequ | uence of): | | | | | | |
| 7 | pg 27 | | | - | b | _ | _ | | | | | | | |
| 0, | be execu- ician and burial-tra | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | J | | Due to (or as | a consequ | uence of): | | | | | | |
| 3760, | 2 52 | | that initiated events resulting in death) Last | 1 | 0. | Due to (or as | a consequ | ience af): | | | | | 1 | |
| 89 | seath certificat attending phy if for use as th | | | L | | | | | | | | | | |
| Box | end bear | | | - | d. | | | | | | | | 1 | |
| | e death the atter | | Part II. Other significant cond | itions co | ntributing to death b | out not resulting | a in the un | derlying cause o | siven in Part I. | 23h Did | tobacco | uee contribu | ite to the cause | of death? |
| P.O. | that the d ed by the detached | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the | | | | | | | | | Unknown | | |
| ls, | 1 68 | by | | | | | | | | | | - | | |
| Records, | s faw requir has been s te 2 should | pleted | | | | | | | | 24s. Wa perl | an auto ormed? | pay 24 | b. Were autopsy evaileble prior completion of of daath? | rto |
| | The I | Compl | | | | | | | | 132 | Yes 2 | □No | 12 Yes 20 | □ No |
| Vital | in in in in in in in in in in in in in i | Be | 25. Was case referred to medi | cal. | | | | | 26. Place of De | ath (Check only | | | | |
| | | 0 | examiner? 1X Yes 2 No | 1 | Hospital: 1 ☐ Inpatie | ent 2□ER/ | Outpatient | 3D DOA | thar | lome 5 ☐ Res | | 6 DiOther /S | pecity) SCEN | IE. |
| Division of | ding Phy th. : Afterthi s funeral | ertification: T | 27. Manner of Death 1 □Natural 5 □ Pen | ding | 28a. Date of Inju | ry ry Year) 28t | b. Time of Injury | 28c. Inj W | | 28d. Describe | how inju | ry occurred | | |
| S | Atten or deal octor by the | fica | 3 Suicide 6 □ Cou | id not be | 0 | / | farm, stru | | | 28f. Location | (Street a | nd Number or | Rural Route Nu | |
| Ö | aher des Director I in by the | ET. | 4 Homicide | imined | building, et | tt. (Specify) | T. | - F | | City or To | wn, Stat | 9) | _ , | ade |

14

To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di-

State Registrar

Medical Certification:

morron SEP 0 9 1997

completed causa of daath (Itam 23e) (Type, Print)

29b. Signature and title of cent

29a. Certifier (Check any one)

30. Name and add

111 Penn Street, Baltimore, Maryland 21201

1 Certifying Phyeicien: To tha best of my knowledge, deeth occurred et the tima, deta end placa, end dua to the causa(s) and menner es statad.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner stated.

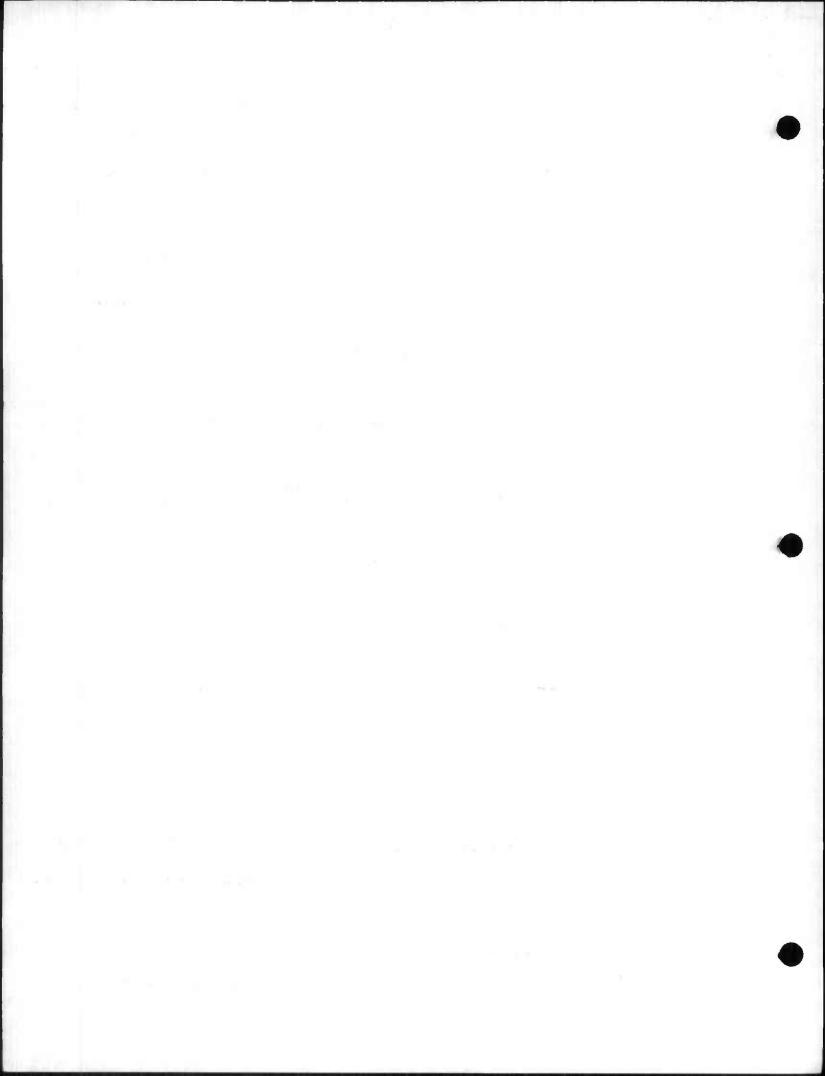
29c. License number

OCME

281. Location (Street and Number or Rural Route Number, City or Town, State) Wordoldthe Patrux Athany. Howard G

29d. Date signed (Month, Dey, Year)

SEPTEMBER 01, 1997



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Death 3. Time of Death SEPT. 1997 Chang Gyu Park 2:45pm 4e. Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death 1808 Village Square Court Severn Anne Arundel 6. Sax 1 M 2 ☐ F If Undar 1 Year If Under 24 Hrs. Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Days Hours Yrs 74 MAY 10, 1923 Korea Usual Residence of Dacedant 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Severn 1 Yas 2 No 10f. Zip Code 10g. Citizan of What Country? 1808 Village Square Court 21144 Korea 12. Wes Decedent Evar in U,S. Armed Forcas?

1 Yas 2 XNo 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indien, Bleck, Whita, atc. 1 Navar Married Married 1 ☐ Yas 2 No Specify: Specify: Asian 3 Widowed 4 Divorced 15. Dacadent's Education (Specify only highast grade complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Printer Advertising 17. Fethar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumame) Inhwan Park Jung Ja Kim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 1808 Village Square Ct. Severn, MD Jae Chul Park/son 20b. Placa of Disposition (Nama of camatary, crematory or other placa) 20c. Location - City or Town, Steta 1 Buriai 2 Cremation 3 Ramoval from Stata
4 Donation 5 Othar (Spacify) Metro Crematory, Inc. 09/08/97 Baltimore, MD 22. Nama end Addrass of Facility Cremation Society of Maryland, Inc. 21. Signature of Funegal Service 10/ CDonald 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Batween Onset end Daeth Gostric adenocorcinome months Due to (or as a consequence of): Due to (or as a consaguance of): 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Wara autopsy findings evailable prior to 24a. Was an autopsy performad? completion of cause of daeth? 2 0 No 1 Yas 1 Yes 2 No 26. Place of Daath (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatiant 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 28d. Describe how Injury occurred

/Medical Examiner The law requires that the daath certificate be executed physician and the buriai-transit P.O. Box 68760, as

cata has been signed by the a page 2 should be detached

this certificata

After

director

Physician

Physician

/Medical

Examiner

Funerai

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Haalth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 and 1 jury or other traumatic event, the Macinal Examination page.

Baltimore, Maryland 21215-0020

the Maryland

5. Social Security Number

10e. Street and Number

20a. Mathod of Disposition

Immediate Cause (Final

diseesa or condition resulting in daath)

NONE.

10a. Stata

MD

Director

Funeral

ρ

Completed

Be

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

Medical

Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaesa or injury that initiated avents rasulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case rafarred to madical axaminar? 1 Yes 2 No 27. Mannar of Death 1 Naturai 2 Accident

5 Pending Invastigation 6 Could not be datarmined

28a. Data of Injury (Month, Day Year) 28e. Piaca of injury - At home, farm, straat, factory, office building, etc. (Specify)

28b. Tima of

28c. Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30

RALTIMORE, MD

29a. Certifier

3 Sulcida

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to the causa(s) and mannar as stated.

Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

TVENUE

29b. Signatura and titla of certifion

30. Nama and address of person who complated cause of death (Item 23a) (Type, Print)

29c. Licansa number

29d. Date signed (Month, Day, Year)

State Registrar

31. Data filad (Month, Day, Yaar) 9 1997 0

DR. OCHANEY

32. Registrar's Signatura his Davidson Pandall

3350 WILKENS

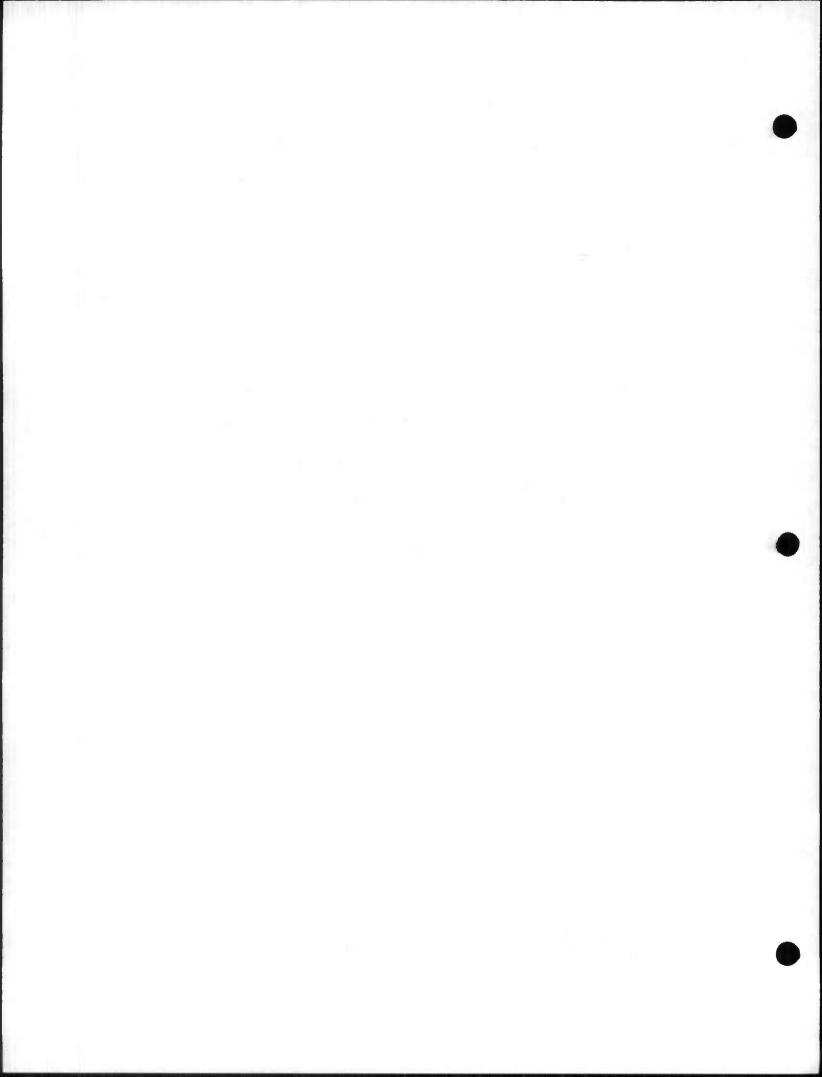
DHMH 16 Rev 6/95

Records, Division of Vital

Hospital or Attending Physician:

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fur

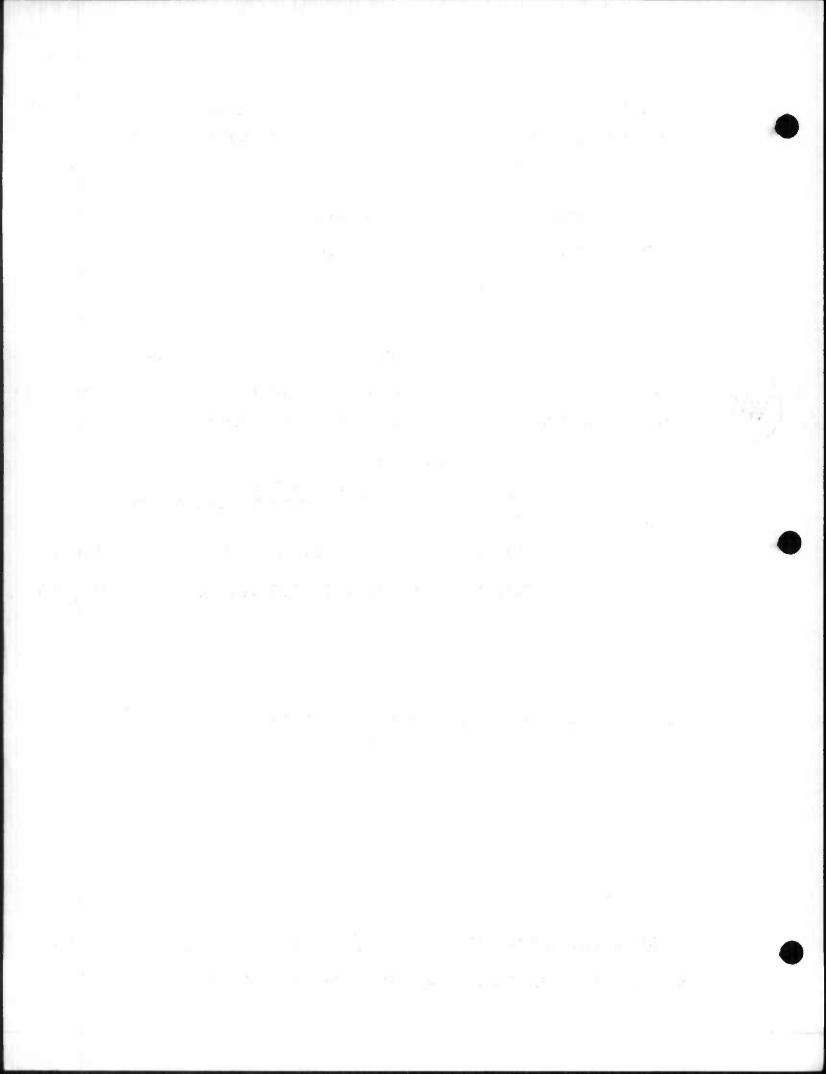


| | Certificate of D | Peath | Reg. No. | | | | | | | |
|--|--|--|--|----------------|--|--|--|--|--|--|
| Physician /Medical | 1. Decedent's Name (First, Middle, Last) TDA PLEET | 2. Date of D. Month. | | | | | | | | |
| Examiner | 4a. Facility Name (If not institution, give street and number) GOOD SAMARITAN HOSPITAL | City, Town, or Location of Dear BALTIMORE | | | | | | | | |
| Funeral Director | | Hours Min. 8. Date of Bi | 9. Birthplaca (State of County) 13, 1918 MARYL | or Foreig | | | | | | |
| P & w | 10a. Stata 10b. County 10c. City, Town or Location | | 10d. inside C | City Limit | | | | | | |
| the Marylar 28a-f show sofffied at ector | MD BALTIMORE OWINGS MILI | LS | 1 Yes | 2 🗆 N | | | | | | |
| th with the Mar 23e or 28e-f s ast be notified al Director | 10e. Street and Number 22 DEER LODGE CT., APT. A 2111 | 17 | 10g. Citizen of What Country? USA | | | | | | | |
| ural; or items 23e or 28e-t aho it Examiner must be notified at id by Funeral Director | Armed Forces? If Yes, specify Cuban, 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No □ □ | panic Origin? (Specify Yes or N., Mexican, Puerto Ricen, atc.) Specify: | o- 14. Race - American Indian, Black, White, etc. Specify: WHTTE | | | | | | | |
| or the Medical. | 15. Decedent's Education (Specify only highast grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupett (Give kind of work done du life. DO NOT use retired) HOMEMAKER | ion ning most of working | 16b. Kind of Business/Industry OWN HOME | | | | | | | |
| Be C | | 18. Mother's Neme (First, Middle | | | | | | | | |
| 2 1 | NATHAN LOUIS WEINSTEIN | GERTRUDE | LAZARUS | S | | | | | | |
| PAL | 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street an | nd Number or Rural Route Numb | per, City or Town, State, Zip Code) | | | | | | | |
| | BEVERLY ZUKERBERG (DAUG.) 7956 STARBURST | r DR. BALTIMO | DRE, MD 21208 | | | | | | | |
| | 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State | | | | | | | |
| ury or | t Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) SHAAREI ZION | 9/7/97 | ROSEDALE, MD | | | | | | | |
| Depart Import any in once. | | NSON & BROS., I STERSTOWN RD., | PIKESVILLE, MD 21208 | | | | | | | |
| nysician Medical | Immediate Cause (Finel disease or condition a INTRACTABLE BR | | Onset and | Death | | | | | | |
| xaminer | resulting in deeth) a. Due to (or es e consequence of): | 11 2 10/11/2 | 001100 | NU | | | | | | |
| sit en | I I SCHEMIC Heart | DISEAS | E Dyea | als | | | | | | |
| burial-transit | | | J | | | | | | | |
| buria | Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events. | | | | | | | | | |
| ing physe as the | that Initiated events resulting in death) Last Due to (or as a consequence of): | | | | | | | | | |
| e attendi | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given | in Part I. 23b. Dld | tobacco use contributa to the causa | of death | | | | | | |
| igned by the be detached by Physic | Chronic obstructive pulmonary dis | | |] Unknov | | | | | | |
| should should | | 24a. Was | s an autopsy ormed? 24b. Were autopsy available prior to completion of death? | to | | | | | | |
| @ cr () | | 1 🗆 | Yes 2⊠No 1 Yes 2□ |] No | | | | | | |
| rector, pag | examiner? | 26. Place of Death (Check only | one) | | | | | | | |
| Pis di | 1 ☐ Yes 2 € No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: | 4 U Nursing Home 5 U Hes | | | | | | | | |
| eath. or: After the fune cation | 27. Manner of Death 1 🖼 Natural 5 — Pending 2 — Accident investigation 3 — Suicide 6 — Could not be | how Injury occurred | | | | | | | | |
| urs aftar d rai Direct lled in by | determined 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) | 28t. Location (City or To | (Street and Number or Rural Route Num wn, State) | n <i>ber</i> , | | | | | | |
| within 24 hours after To the Funeral Dir completaly filled in Medical Cert | 29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, (Check only one) 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, (Check only one) 2 ☐ Medicat Examiner: On the basis of exeminetion and/or Investigation, in my opin and manner stated. | nion, deeth occurred et the time, | date and placa, end due to the cause(s | s) | | | | | | |
| To the | 29b. Signature and title of certifier P105 | 85 | Sept, 5, 199 | + | | | | | | |
| 5 | 290. Signature and title of certifier N. D. P105 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) KABALAN YANNINE, 5601 LOCH RAV | IEN Blvd, BAL | TIMORE, MD, 2123 | 39 | | | | | | |

DHMH 16 Rev 6/95

Registrar

SEP 0 9 1997



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 27337

| | | | | | Certificate of | f Death | R | leg. No. | 114 | | | |
|--|-----------------------|--|--|-------------------------------------|--|---|--|--|---------------------------|-------------------------------------|--|--|
| Dharais | ta | 1. Decedent's Nema (First, Middla, L | | | 2. Data of Death | | Yaar | 3. Tima of Death | | | | |
| Physic /Med | | IRVING | | | PULITZER | | SEPT. | | 1997 | 6 AM | | |
| Exam | | 4e. Fecility Nema (If not institution, g | ive street and number |) | | 4b. City, Town, or L | ocation of Deeth | of Deeth 4c. County of I | | | | |
| | ,_ | JEWISH CONVALESCENT CENTER BALTIMORE BALTIMORE | | | | | | | | | | |
| Funera Director | _ | 5. Social Security Number 6. 107–16–1716 Usual Residence of Dacedant | Sex 7. A 1 X M 2 □ F | ga (In yrs. last bii 85 | Yrs. If Under 1 Year Months Dey: | | 8. Data of Birth Month Day MAR . 5, | 1912 | 9. Birthp | place (Stata or Foreign NEW YORK | | |
| the Maryland 28a-f show notified at | tor | 10a. Stata 10b. County 10c. City, Town or Location MD N/A BALTIMORE | | | | | 10d. Inside City | | | | | |
| with the M 3s or 28s-f st be notifie | Il Director | 10e. Street and Number 4002 CLARKS LANE | | | 10f. Zip Coda 21215 | | | 10g. Citizan of What Country? USA | | | | |
| SWH) | d by Funeral | 11. Marital Status 1 □ Navar Marriad 2 □ Married 3 ☒ Widowed 4 □ Divorced | 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Giva Yaar or Detes: | | 13. Was Dacedant of Hispanic Origin? (Specify Yes if Yas, specify Cuban, Maxican, Puarto Rican, at 1 ☐ Yes 2 ☑ No Specify: | | pecify Yes or No- Rican, atc.) | 14. Race - American Black, White, at Specify: WHIT | | itc. | | |
| | iğ. | 15. Dacadant's E (Specify only highast g | Education rada completed) | 18a | Decedent's Usual Occi | upation e during most of work | aina | 16b. Kind of B | usinass/Inc | dustry | | |
| 2 11 | Compl | Elamantary/Secondary (0-12) | Collega (1-4or | 5+) | (Giva kind of work don lifa. DO NOT usa ratii MATLMAN | red) | 9 | II S | COVER | NMENT | | |
| C Party | ပိ | 17. Fathar's Nama (First, Middla, Las | a (act) | | | | Mother's Name (First Middle 4 | | U.S. GOVERNMENT | | | |
| Maryland 2 should be file th and Mental Hy 7 is marked oth | To Be | | | | | | me (First, Middla, Maiden Surnama) TRUDE EPSTEIN | | | | | |
| Mar 2 sp 1 s m 1 s m | | 19a. Informant's Name/Relationship | | | . Mailing Address (Strat | | | | | | | |
| - E - N - | | MRS. CYNTHIA H | EINECKE (S | | DAU) 4002 | CLARKS LA | | LTO., M | | 1215 | | |
| Or of High | | 20a. Mathod of Disposition 1X Burial 2 □ Cramation 3 | ☐Removel from State | comoto | f Disposition (Nama of ry, crematory or other pi | lace) | Data | 20c. Location - | City or To | wn, Stata | | |
| Baltimore, semit. Pages 1 a bepartment of Hea montants if Item: my injury or other fice. | | 4 Donation 5 Othar (Spec | | 5.000 | VETERANS | 9/ | 497 | OWING | S MIL | LLS, MD | | |
| Ball Semit Depart mport mport any in | | 21. Signature of Funeral Service Loc | msec | | 22. Name and Add | | OC TN | | | | | |
| m 20199 | | 80UMAN 7 | Nuon | | | INSON & BF ISTERSTOWN | | | TE N | 4D 21208 | | |
| | Г | 23a. Part1. Entar tha disaasa, or cor shock, or haart failura. List only | nplice that cause | d tha daath. Do | not antar tha moda of dy | ying, such as cardiac | or raspiratory arr | ast, | LE, P | Approximata | | |
| Physician | | Shock, or haart failura. List only | y one sause on aach | una. | 2 2 | | | | | Intarval Batween Onset end Daath | | |
| /Medical | | Immediate Causa (Final disease or condition rasulting in death) Due to (or as a consequence of): Attempting to the condition of the conditio | | | | | | | | | | |
| Examiner | | | | | | | | | | | | |
| | ē | | 21/100 | Due to (or as a | consaduence of | 22116.00 | culon | 1)500 | 197 | 3489 | | |
| her | Examiner | | 1 6. 177 NO | DIVICE | 116 10 | (1)(00-> | | 1.1714 | , — | 3 1 100 | | |
| be executed siclan and burial-transit | Exa | Sequantially list conditions, fany, laading to immadiata causa. Entar Undarlying Causa (Disaase or Injury c. | | | | | | | | | | |
| do rou, fficata be ex g physician as the burial | | that initiated avants | | | | | | | | | | |
| physi s the | edlcai | rasulting In death) Last Dua to (or as a consequence of): | | | | | | | | | | |
| Se as t | 2 | | | | | | | | | | | |
| eath cert attandin I for use | clar | | | | | | | | | | | |
| d by the | ysi | Part II. Other significant conditions | contributing to death | but not rasulting l | n tha underlying cause g | given in Part I. | 23b. Did to | obacco use co | ntribute to | the cause of death? | | |
| that the death ce ed by the attandi detached for us | by Physician/ | (andestin | r INBE | URC, 10 | | | Yes 2 No 3 Probably 4 Unknow | | | | | |
| 0 2 6 8 | | 11/11/11 | 0 | 1 ' | 1.1 | | 24a. Was a | in autoney | 24h We | era autopsy findings | | |
| v require been sis | Completed | 10/2/4/01 | S Nou | -ub.t | 12 0 166 | RS. | perfor | mad? | ava | altabla prior to | | |
| e law l | Idu | | | | | | | | | death? | | |
| The la | S | | | | | | 1 □ Y | es 2 No | 10 | ☐ Yes 2☐ No | | |
| Physician: The rhis certificate and director, pag | Be | 25. Was casa referred to medical axaminar? | | | | 26. Place of Deal | th (Check only or | na) | | | | |
| - X 00 | 2 | 1 ☐ Yas 2 ☐ No | Hospital: 1 Inpat | iant 2□ER/Ou | utpatient 3□ DOA | Othar: 4 Nersing Ho | ome 5 Reside | ence 6 DOth | er (Specif) | y) | | |
| OLVISION OF lor Attending Phys after death. Director: After this d in by the funeral di | :uc | 27. Mannar of Death 1 □ Watural 5 □ Pending | 28a. Date of Inj (Month, D | ury 28b. | Tima of 28c. Inj | ury at | 28d. Dascribe he | ow Injury occur | red | | | |
| Attending r death. sctor: Afta by the fune | ati | 2 ☐ Accidant invastigation | | | M 1[| □Yas 2□No | | | | | | |
| rect by t | tlfic | 3 ☐ Sulcida 6 ☐ Could not determined | ⊣ ≥8a. Place of if | jury - At homa, fa tc. (Spacify) | rm, straat, factory, office | 8 | 28f. Location (S. City or Town | | oer or Rura | al Routa Number, | | |
| ed in grand of the control of the co | Cer | | | | | | | | | | | |
| DIVISION O To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral | edical Certification: | 29a. Certifier 1 Check only one) 1 Madical Exa | hyalclan: To the best minar: On the basis of and manners | of axamination an | , death occurred at the d/or invastigation, in my | tima, date and place, opinion, daath occur | and dua to tha c red at the tima, d | ause(s) and ma late and placa, | annar as st and due to | lated. tha cause(s) | | |
| To the within ? | Me | 29b. Signatura and titla of cartifiar | - | | 29c. Licar | nsa nu <i>m</i> ber | 2 | 9d. Date signe | d (Month, | Dey, Yaer) | | |
| F 3 F 0 | | 10010 | Vini | 0. | 2 | 5753 | | 9/21 | 100 |) | | |
| | | 1000 | 2 10006 | The open | | (1)33 | | 110 | 17 | 1. | | |
| 0 | | 30. Name and address of person who | completed cause of | daath (Itam 23a) | (Type Print) | Randp | 11940 | Jucy 1 | Mar | A 1000 | | |
| St Regist | ate rar | 31. Data filed (Month, Day, Year) SEP 0 9 1997 | 32 Regist | 7 | andell | | | · | | | | |

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

Month

27338

3. Tima of Death

Physician /Medical Examiner

1. Decedent's Name (First, Middla, Last)

Day 1997 Aug 15, 12:31 EDWIN FRANCIS PRYCE, JR 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Catonsville Baltimore Charlestown Care Center If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 9. Birthplace (State Country)

April 9, 1915 Maryland If Undar 1 Yaar 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 □ F 82 Yrs Director 213-01-0570 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Catonsville 1 ☐ Yes 2 ☑ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? an "natural", or thems 23a or Medical Examiner must be n permit. Pages 1 and 2 should be filed within 72 hours after death 1. Department of Health and Mental Hygiens. Important: If them 27 is meried other trans 'neturals, or thems 23a any injury or other traumetic event, the Medical Examination 2006. 709 Maiden Choice Lane U.S.A.

14. Race - American Indian,
White, atc. Funeral 21228 12. Was Decedant Evar in U.S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuben, Mexican, Puerto Rican, etc.) 1 Yes 2 No if Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No White ď Specify: 3 Widowed 4 Divorced Completed 18a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Draftsman Stee1 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Malden Surnama) Edwin Francis Pryce, Sr. Jane Watson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Nancy Pryce/neice 10 S. Gate Road, Myrtle Beach, S. Carolina 29572 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ade Director Wade State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 Ronald Sa nance Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death **Physician** /Medical fmmediete Cause (Finat disease or condition resulting in death) Pancreatie Cancer months Examiner Due to (or as a consequence of) Physician/Medical Examiner ettending physician and for use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disaasa or Injury that initiated events Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) resulting in death) Last signed by the e Part ff. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 DUnknown ģ 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? page 2 has 1 Yes 2 No 1 Yes 2 No certificate or Attending Physician: director. 25. Was case referred to medical examiner? 28. Place of Death (Check only ona) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatienf 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yas 2 No After this funeral 28a. Date of injury (Month, Day Year) 27. Menner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 24 hours after death. 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicide 28e. Placa of Injury - At homa, farm, streat, factory, offica building, etc. (Specify) filled in by 4 Homicide Hospital 1tt Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the F within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (item 23a) (Type, Print) D51051 August 15 711 Maiden Choice lane, Catousville, MD, 21228

State Registrar Andres Salazar

31. Date filed (Month, Dev Year)

9-4-3-1

| SP Items: | 23a i | part I,27 per MEO G-75 | | ylanu / | Department of Certificate or | | | eg. No. | 7 2 | 2733 | 39 |
|--|----------------------------|---|--|----------------------------|---|--|--|----------------------------|--|---|----------------------|
| 10011101 | -00 | 1. Decedant's Name (First, Middle, La | | | | | 2. Date of Deat | - | | 3. Tima of | Death |
| Physi /Med | | David M. | Pierce | | | | JULY | 2 ⁸ y 1 | 997 | 9:05 | 5 A |
| Exam | | 4a. Fscliity Name (If not institution, giv | | | | 4b. City, Town, or Lo | ocation of Death | 4c. County | of Death | | |
| | | 1824 HARFORD | RD. | | | BALTIMO | RE | Balt. | imore | City | |
| Funera | 1 | 5. Social Security Number 6. S | | In yrs. iast l | oirthday) If Undar 1 Yas Months Day | | 8. Date of Birth (Month, Day, | | | ace (Stata o | |
| Directo | _ | unknown | ⊠M 2□F 67 | | Yrs. Months Day | s Hours Mill. | April 1 | | | nknow | |
| р , | 7 | Usual Residence of Decedant 10a. State 10b. County | | 0 0 T | | | *** | ., ., | | | |
| anyla | | | | | wn or Location | | | | 10 | od. Insida Ci | |
| M es M | 5 | | roe City | Balt | imore | | | | | 1-X Yes | 2 LJ NO |
| laryland 21215-0020 2 should be filed within 72 hours after death with the Manyland and Mental Hygiene. Is marked other than "natural", or items 23s or 28s-f show aumstic event, the Med call Examiner mass be notified at | Director | 10e. Street and Number | | | 10f. Zip Code | | 16 | og. Citizen of \ | What Coun | try? | |
| ath v | 100 | 1824 Harford Roa | | | | more 21215 | | unknow | | | |
| er de | Funeral | 11. Maritai Sfafus unknown | Armed Forces? unknow | | | S. 13. Was Decedant of Hispanic Origin? (Sp If Yes, specify Cuban, Maxican, Puerto | | | e - America ck, Whifa, a | | |
| S office of the second | by Fu | 1 Never Married 2 Married | 1 Yes 2 No If Yes, Give Year or Dates: | | 1 ☐ Yes 2 ☐ N | Specify: | | Specify | Bla | ale | |
| 21215-0020 d within 72 hours aff giene. In then "netural", or then "netural", or then "netural", or then "netural", or the man call Exert in the man call | D D | 3 Widowed 4 Divorced | | | | | | | | | |
| 72 72 | ete | 15. Decedent's En (Specify only highest gra | ducation ade completed) | 16 | a. Decedent's Usual Occ (Give kind of work don life. DO NOT use retii | upation e during most of work | ing | 16b. Kind of B | usiness/Ind | ustry | |
| Neithir Man | Completed | Eiementary/Secondary (0-12) | College (1-4or 5+) | | | | | 1 | | | |
| Hygied N. | | unknowt; 17. Father's Name (First, Middle, Last, | unknown | | unknown | 18. Mother's Nam | e /First Middle A | unknov | | | |
| ntai be d | Be | unknown | , | | | | | nanoon Gornan | 10) | | |
| aryland 212: should be filed within nd Mental Hygiene. marked other then imatic event, the M. | 2 | 19a. Informant's Name/Relationship (| Time Orint | - 4 | No. & Aprilian Andriana (Cara | unknown ess (Street and Number or Rural Route Number, Ci | | | 200 - 70 - 60 - 60 - 60 - 60 - 60 - 60 - | | |
| Maryland of 2 should be file lith and Mental Hy 27 is marked other traumatic event | | unknown | Type, Filmi) | 13 | unknown | st and Number of Hur | ar mobile ryumber, | Chy or Town, | State, Zip | Code) | |
| Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filled within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than *natural; or items 23s or 28=7 show any injury or other traumatic event, the Medical Examiner must be notified at | | 20a. Method of Disposition | | 20h Place | of Disposition (Name of | | Date 2 | 20c. Location - | City or To | un State | |
| or of the state of | | 1 Buriai 2 Cremation 3 C | Removal from State | ceme | ery, crematory or other p | lace) | Duto . | LOG. LOGGIOTI | Oily of To | Wii, Otata | |
| timer tant | | 4 □ Donation 5 ☑ Other (Specif | | e | | | | | | | |
| Baltimore, pemit. Peges 1 an Department of Heal Important: if item 2 any injury or other | | 21. Signature of Funeral Service Licer | ade. Direct | or | 22 Nama and Add State Ar | ress of Facility latomy Boar | rd, 655 | W. Balt | imore | Stre | et |
| M 00500 | | mondell | Millas | ec. | | e, Maryla | | | | | |
| Physiciar /Medica Examine | | fame the disease, of com- body, or heart failure. List only famediate Cause (Final disease or condition resulting in death) | a. HYPERTENSI | VE ARTE | RIOSCLEROTIC (| | | | | Interval Bett Onsaf and I | Death |
| . BOX 68/60, leath certificate be executed a strending physician and dror use as the bunel-transit | Physician/Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last | c | | a consequence of): | | | | | | |
| ath ca | 200 | | 0. | | | | | | İ | | |
| at the de de de de de de de de de de de de de | Sic | Part II. Other significant conditions of | ontributing to death but r | not resulting | in the underlying cause (| given in Part I. | 23b. Dld to | bacco use co | ntribute to | the cause o | of death |
| es that the de igned by the | by Ph | | | _ | | | 1 □ Ye | s 2 No | 3 Prot | ably 4 | Unknow |
| v requir | Completed | | | | | | 24a. Was as perform | | COL | re autopsy f niable prior for nplation of c death? | indings o ausa |
| The International | E O | | | | | | 1 1 1 Ve | s 2 No | 1/2 | Yes 2 | No |
| ysician: The lav ysician: The lav is certificate hes director, page 2 | BeC | 25. Was case referred to medical | | | | 26. Place of Deat | th (Check only on | e) | | | |
| S Cert | ToB | examiner? 1 ∑ X es 2 □ No | Hospital: | 2 □ FB/0 | Outpatient 3 DOA | Mb a s | ome 5 A Reside | | er (Specifi | () | |
| F F F F | n: | 27. Manner of Death | 28a. Date of Injury (Month, Day Y | | | 28c. Injury at Work? | | | | | |
| ath. | atio | 1 XXNatural 5 ☐ Pending 2 ☐ Accident investigation | | ear) | | ☐ Yes 2 ☐ No | | | | | |
| To the Mospital or Attending Ph Within 24 hours effer death. To the Funeral Director: After thi completely filled in by the funeral | Certification: | 3 Sulcide 4 Homicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Run City or Town, State) | | | | | | | per or Rura | Route Num | ber, |
| Hospita 24 hours Funeral etely fille | edicai C | 29a. Certifier 1 Cartifying Ph (Check only one) 2 Medical Example | yalcfan: To the best of n nIner: On the basis of ex and manner state | my knowled kamination a | ge, death occurred at the and/or investigation, in my | time, data and place, opinion, death occur | and due to the ca red at the time, da | use(s) and mate and place, | anner as st and due to | ated. the cause(s | ;) |
| of the | Me | 29b. Signature and title of certifiar | | | | nsa number | 29 | 9d. Date signe | d (Month, | Day, Year) | |
| ->-0 | | Theodor | M. Kin | | | O.C.M.E JULY 29,1997 | | | | | |
| | | 30. Name and address of person who THE DE NE M 31. Date filed (Month, Day, Year) SEP 0 8 1997 | completed cause of deal | h (Item 23a |) (Type, Print) L11 Penn S | tt D | al+imo | co Ma | rvla | nd 2 | 120 |
| | | 31. Date filed (Month, Day, Year) SEP 0 8 1997 | Bry | L | III Penn S | treet, B | атсыю | .e, He | Lyro | | |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Deeth

10d. Inside City Limits

Approximate intervel Between Onset and Death

1 ☐ Yes 2 ☐XNo

Physician /Medical Examiner

1 Decedent's Neme (First Middle Lest)

Mildred Marie Peyton

9:25 pm

Baltimore

Funerai Director

c ZBa-f show

must be n

ns 23a

Director þ

Completed

should be a marked yes 1 and 2 ah, important of Health and h important. If Ison 27 is meany injury or other.

Baltimore, Maryland

Box 68760

P.O.

Records,

Division of Vital

Physician /Medical Examiner

buriel-transit end physiclan s the buriel ettending p signed by t has e 2 page Hospital or Attending Physician:
 124 hours after death.
 Funeral Director: After this certificialistic in by the funeral director, Be Medical To the Hosp within 24 hor To the Fune completely fi

Examiner Physician/Medical Completed by Certification: To 29a. Certifier

September Day, 1997 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Rossville Meridian Franklin Woods If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Deys Hours Min. Aug. 1, 1925 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2□F 72 Yrs 214 40 2106 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location Maryland Baltimore Middle River 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Apt. "1D" 21220 305 Nitram Court USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: White 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Housewife Own Home 17. Father's Name (First, Middla, Last) 18. Mother's Neme (First, Middla, Maidan Sumama) John Stevens Margaret 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 4945 Bucks School House Road Baltimore, Md 21237 19a. Informant's Name/Relationship (Type, Print) Roberta Jean Peyton (niece) 20b. Place of Disposition (Nema of camatary, cramatory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Buriai 2 ☐ Cremetion 3 ☐ Removal from State Holly Hill Mem. Gardens 9/8/1997 Baltimore Co., Maryland Donation 5 Other (Specify) Bruzdziński Funeral Home P.A. 1407 Old Eastern Ave Essex, Maryland 21221 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. PULMONARY FIBROSIS Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as e consequence of) Due to (or as a consequence of):

Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. ONONARY APPENY DISEASE OSTEOPONOSIS

28a. Dete of Injury (Month, Day Year)

24a. Wes en autopsy performed?

28c. Injury at Work?

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No 26. Piece of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

25. Wes case referred to medical exeminer? 1 ☐ Yes 2 No 27. Manner of Death

4 - Homicide

1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Sulcide

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28f. Location (Straat and Number or Rural Route Number, City or Town, State) 🖹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the ceuse(s) and manner as atated.

(Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and little of certifier

31076

1 Tyes 2 No

6830 Hosni Tar OR. BARD

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

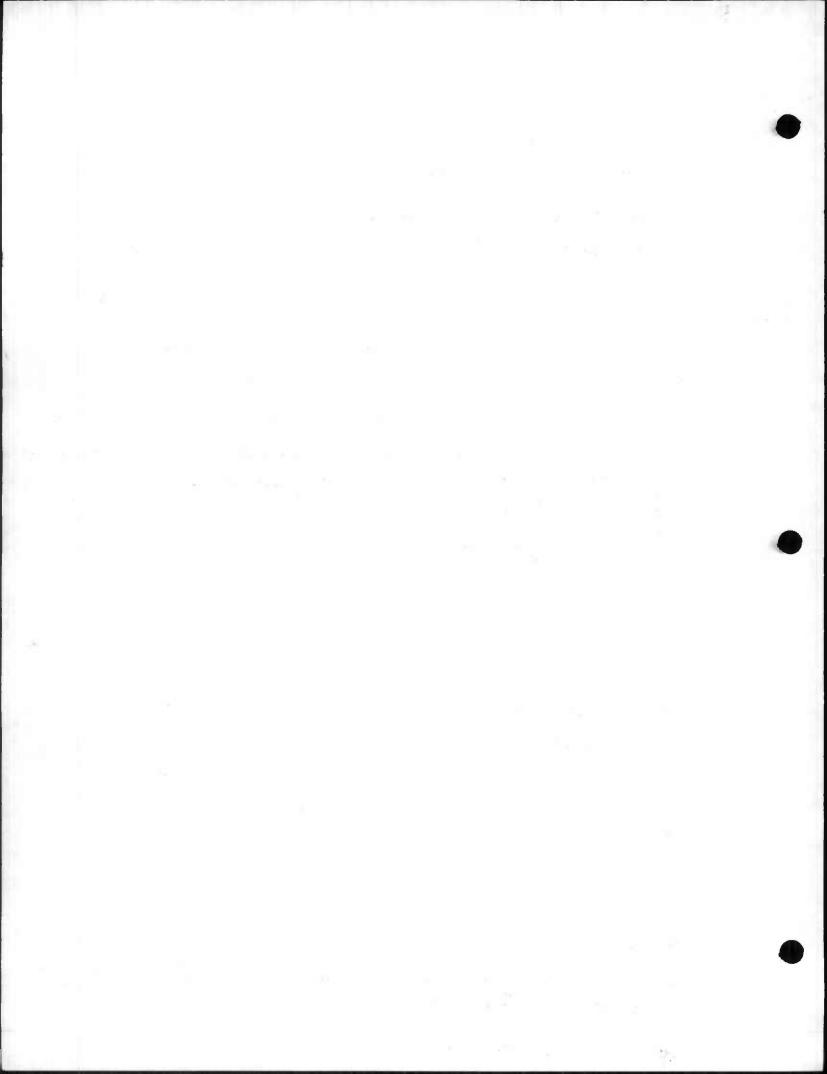
30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

A SSON M.O.

State Registrar

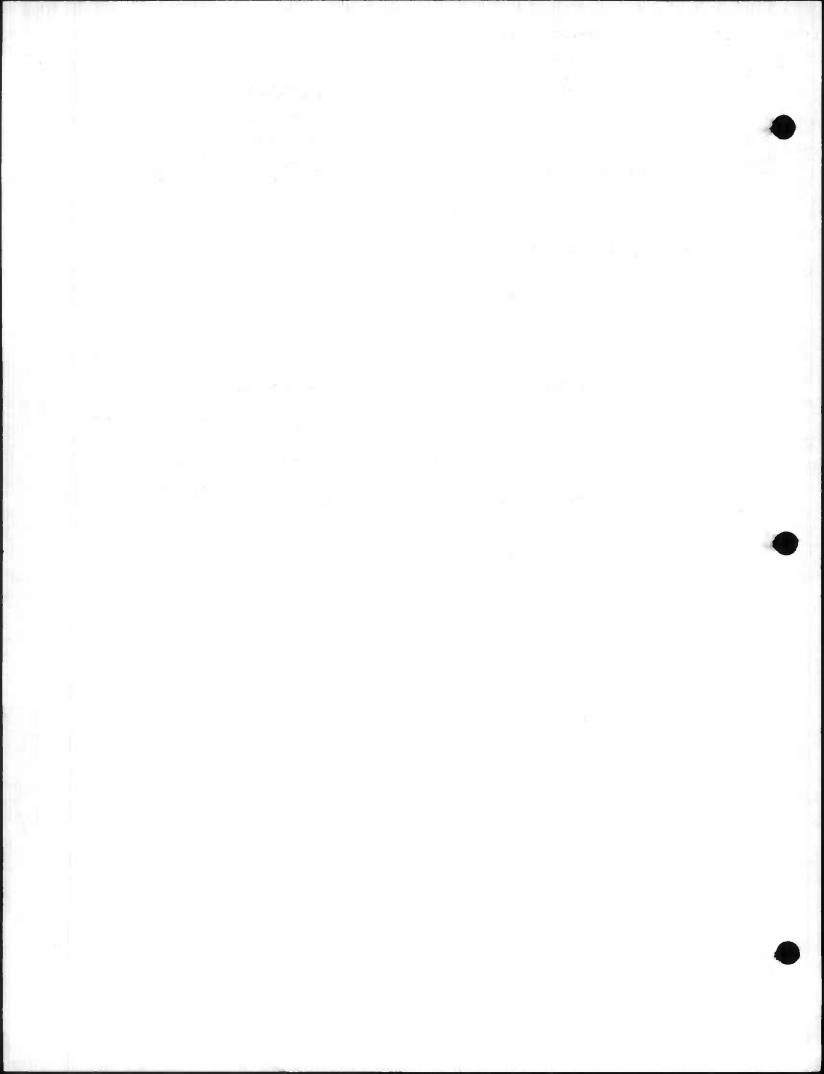
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1. 1. Ballagara's Monduess 31. Date filed (Month, Dey, Year) 0 9 1997



State of Maryland / Department of Health and Mental Hygiene 97 2734

| | | | | | | | Ce | ertifica | ate of | Death | | | Reg. No. | | - ' | 0 1 . |
|---|---|----------------|---|---|--|---|----------------------------------|--------------------|------------------------|---|--------------------------------------|------------------------------------|-------------------------------|---|----------|--------------------------------|
| | Physic | ian | | me (First, Middle, L | | | | | | | | . Date of De | eath Day | Year | | ime of Death |
| | /Medi | | ROB | ERT RO | BINS | 10 | | | | | 2 | EPTER | ABER | 1 1997 | 7 | : ZZ p. |
| | Exami | | | (If not institution, gi | | | | | | 4b. City, Tow | n, or Loca | tion of Deat | h 4c. Cour | nty of Death | | |
| | | | | DSPITAL | OF BA | LTIMO | RE | | | BALT | | | n/a | | | |
| | Funeral Director | 1 | 5. Social Sacurity 220–20–2 | | Sex 15AM 2□F | | s. last birthda 65 Yrs. | y) If Unc Month | | If Under 24 | Min. | Date of Bir (Month, De Ct. 3 | th ly, Year) 1931 | 9. Birthp Coun | lace (S | Stata or Foreign |
| | pu » | | Usuai Residenca 10a. Stata | 7 | | 100 | Sibe Tours on I | Lacation | | | | | | | - 1 - | |
| | e Maryla | Director | Md. | n/a | | | altimoi | | | | | | | ' | | ide City Limits Xyes 2 □ No |
| | th with th | | | | | | | | | | 10g. Citizen of What Country? USA | | | | | |
| | 72 hours after death with the Maryland naturel; or items 23a or 28a-f show ofcal Examiner must be notified at | by Funeral | | mied 2 Married 4 ☑ Divorced | 12. Was Dec Armed Fo 1 Ty Yes If Yes, Gi Year or D | edent Ever in orces? 2 No ive Datas: 1 | u,s. 13 | If Yes, sp | edent of becify Cul | Hispanic Origi ban, Mexican, Specify: | in? (Specif Puerto Ric | fy Yas or No can, etc.) | В | ace - Americ lack, White, City:Blac | etc. | an, |
| | n 72 hours "naturel", | Completed | (Cn. | 15. Decedent's E | ducation | | 16a. Dec | edent's Us | suai Occu | ipation during most of | nd interdule a | | 16b. Kind of | Business/Ind | dustry | |
| | within one. | ple | Elementary/Sec | ocify only highest gr | College (| | life. | DO NOT | use retin | ed) | or working | | | | | |
| | 2 should be filed within and Mentel Hygiene. Is marked other than aumatic event, the M | 5 | 12th Gra | ade | | | Inspe | ector | | | | | Crown | Cork | & So | eal |
| | be file d oth | 36 (| | (First, Middle, Las | • | | - | | | | | | , Maiden Sum | ame) | | |
| | Mentel Mentel arked o | To Be | Robert F | Robins SR | • | | | | | Annie | e Wal | ker | | | | |
| | and I me | | 19e. informant's I | Name/Relationship | (Type, Print) S: | ister | 19b. Me | iling Addre | ss (Stree | et and Number | or Rural F | Route Numb | er, City or Tow | m, Stata, Zip | Code) | |
| | 1 and 2 Health em 27 l | | Marion Ha | | | | 4216 | 6 Cra | wfor | d Avenu | ue Ba | ltimo | re, Md. | 2121 | 5 | |
| | other other | | 20a. Method of Di | | | | Piace of Disposers, ce | position (A | lame of | ace) | | Data | 20c. Location | n - City or To | wn, Sta | ate |
| | permit. Pages 1 and 2 should be filed within 72 ho Deperment of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical DIDE. | | 4 Donation | 2 Mikremation 3 [5 ☐ Other (Speci | ify) | Stata | arrisor | 1 For | est ' | Veterar | | | Owings | | | |
| | permit. Depertr Importu any Inje | | 21. Signature | uneral Service Lice | - 15mm | | 2 | 22. Name 2501 | and Addr | ess of Facility | Nutt | er Fu | neral H ltimore | iomes, | Inc | 216 |
| | | | 23a. Part1. Enter | the disease, or con ert failure. List only | npiications (iii) | caused the de | | | | | | | | 1100 | Appro | eximete al Between |
| | Physician /Medical Examiner | Examiner | Immediate Ceuse disease or condit resulting in deeth | ion | o. Ho | | (or as a cons | | | IRE | | | | | | t and Death |
| | acut end -tran | хап | Sequentially list of | conditions, | | Due to | (or as a cons | equenca o | f): | | | | | i | | |
| | oe ex | | Sequentially list of if any, leading to cause. Enter Und Cause (Disease of | derlying or injury | ETT | MANOU | - ABL | LSE | | | | | | i i | | |
| | leath certificete be executed the attending physician end of or use es the burial-transit | Medical | that initiated avents resulting in death) Last Dua to (or as a consequence of): | | | | | | | | | | | | | |
| | death c e attend od for us | Slan | | | | | | | | | | | | | | |
| | U W X | ysic | Part II. Other eign | ificant conditions | contributing to d | eath but not re | esuiting in the | underlying | cause g | iven in Part i. | | 23b. Did | tobecco use | contribute to |) the Cr | nuse of deeth? |
| | requires that the de been signed by the chould be detached | by Physician | TIPS | procedu | 12 | | | | | | | 1 🗆 | Yee 2□ No | 3 □ Prot | pably | 4 Minknown |
| | 2 S | Completed | - | | | | | | | | | | an autopsy ormed? | ava | aiiabie | on of cause |
| | E # 2 | Co | | | | | | | | | | 1 🗆 | Yas 25 No | 10 | Yes | 208 No |
| | ician: The certificate rector, pag | Be (| 25. Wes case refe examiner? | erred to medicai | | | | | | 26. Piace o | of Death (| Check only | one) | | | |
| | 0 0 | 2 | | ⊀ No | Hospitai: | Inpatient 2 | ☐ ER/Outpati | ent 3 🗆 | DOA O | ther: 4 Nurs | sing Home | 5 ☐ Resi | denca 8 🗆 C | ther (Specify | y) | |
| | D P | | 27. Menner of Dea 1 Maturai 2 ☐ Accident | th 5 ☐ Pending investigatio | | of Injury th, Day Year) | 28b. Time Injury | | 28c. Inju | uryet ork? ∐Yes 2∐Ne | | d. Describe | how injury occ | urred | | |
| | | Certification: | 2 Accident all Notes Industry and Solicide 3 Suicide 6 Could not be determined 4 Homicide 4 Homicide 4 Homicide 28a. Placa of Injury - At home, farm, street, factory, offica City or Town, State | | | | | | | | | Street and Nui wn, State) | mber or Aura | / Route | Number, | |
| | To the Hospital or within 24 hours afte To the Funeral Dir completely filled in | edicai | 29a. Certifier (Check only one) | 1⊠ Certifying Pl 2 Medical Exa | miner: On the b | best of my ki asis of exami ner stated. | nowiedge, dea nation end/or l | ath occurre | ed at the ton, in my | ime, date and opinion, deeth | piace, and occurred | d due to the at the time, | cause(s) end dete and piac | manner as si e, and due to | ated. | iuse(s) |
| | vithir omp | Me | 29b. Signatura | d titia of certifiar | | | | 2 | 9c. Lican | sa number | | | 29d. Data sig | ned (Month, | Day, Y | ear) |
| / | | | > K | me 1. 7 | rile | enmo | | A | 5 2 | 40232 | 2192 | 8ZAW | SEPTE | MBER | 4 1 | 997 |
| | T) | | 30. Name and edd | fress of person who | completed caus | se of death (It | em 23a) (Туре | e, Print) | AL | OF BA | LTIN | ORE | | | | |
| | Sta | ite | 31. Date filed (Mo. | | P. Sia Bat | | | - 1 / 1 | | | | | | | | |
| | | | 0 - 0 0 | 1007 | "I WAS KNOW | I MINDS | | | | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ROBINSON JAMES SEPTEMBER 4 1=1451 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death CENTER | If Under 1 Year | Devs BALTIMORE 1Edical 6. Sex 18 M 2□ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 50-24-814 South CArolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits NIA BALTIMORE 1 Yes 2 No 10e. Street end Number 10g. Citizen of What Country? 2825 Wood BROOK AVE. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Beth Steel Corp BYRNER 17. Father'a Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) JAMES ROBINSON Robinson - Wife 2825 wood and 20b Place of Disposition (Name of cemetery, crematory or other place) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. tnformant's Name/Relationship (Type, Print) Robiner 2825 WoodbROOK Ave Balto, Md. 21217
Date | 20c. Location - City or Town, State 20a. Method of Disposition 9/8/97 1 Burial 2 □ Cremation 3 □ Removal from State CEMETURY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licansee 22. Name and Address of Fecility BALTO. MU. MITER P.C. FUNE-AL Homet Service 23a. Puril. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, strick, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth Immediate Cause (Final SEPSIS BILATERAL PNUEMONIA WITH DAYS disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown PARKINSONS DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? DIABETES MELZITUS 26 No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed

Physician

/Medical

Examiner

Director

28a-f show

by Funeral Director

Completed

Be

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryle Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "naturel", or items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examinar must be northed as

Baltimore, Maryland 21215-0020

with the Marylend

Physician/Medical þ Completed Be

Examiner

27. Manner of Death

Medical Certification: To filled in by the

Division of Vital Records, P.O. Box 68760,

within 24 hours or To the Funeral C

After

death.

Director: /

State

Registrar

SUDHIR. D.

5 Pending investigation

6 Could not be determined

1 Yes 20 No

1 Naturai

2 Accident

3 Sulcide

29a. Certifier (Check only one)

4 | Homicide

29b. Signature and title of certifier



12 Cartifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

1 Øinpatient 2 □ ER/Outpatient 3 □ DOA

28b. Time of

28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

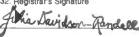
28d. Describe how thiury occurred

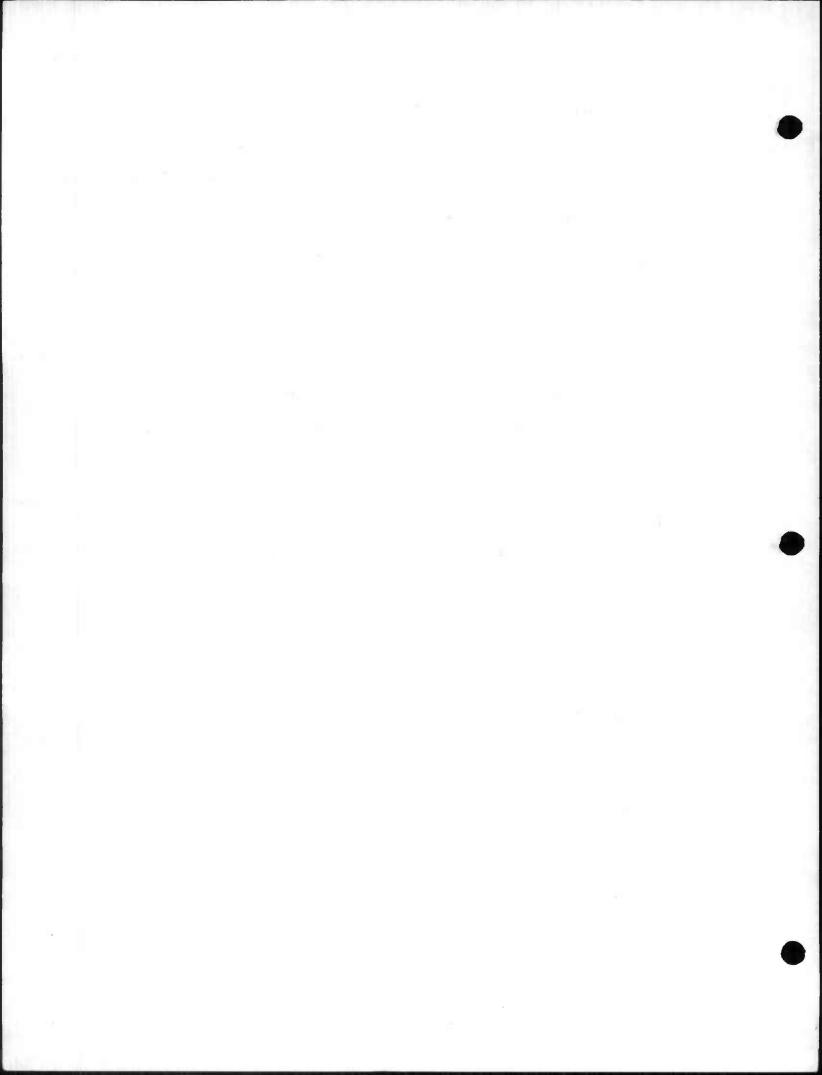
29c. License number 23300 29d. Date signed (Month, Day, Year) SEPTEMBER 4

Liberty Medical Cents, Libesty BALTO,

PATEL. 2600 31. Date filed (Month, Day, Year) 32. Registrar's Signature

SEP 0 9 1997





State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3 Time of Death Month FAT 08:39 **Physician** Rowland Deborah September /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month Dey, Year) MAY 24, 1917 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 25 F 209-16-0144 80 Yrs. Director Pennsylvania Usuei Residence of Decedent the Menylend 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be nothind at 1 ☐ Yes 2 ☐ No Director Luzerne West Pittston 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ò Herns 23a Pages 1 end 2 should be filed within 72 hours efter deeth tent of Heetth end Mental Hygiene.
nt: If Item 27 Ie marked other than "natural", or Itema 23 Funeral 226 Linden Street USA 14. Rece - American Indian, Bleck, White, etc. 18643 12. Was Decedent Ever In U,S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16h Kind of Business/Industry (Specify only highest grade completed) 4^{Collage (1-4or 5+)} Elamantary/Secondary (0-12) Teacher Public School 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Evan Jones Sarah Jones 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rurel Route Number, City or Town, Stata, Zip Code) nt of Heelth e : If Item 27 le or other tra Robert J. Rowland/husband 226 Linden St. West Pittston, PA18643 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stata 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. Metro Crematory, Inc, 09/09/97 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signeture of Juneral Service License 22. Name end Address of Fecility on word Cremation Society of Maryland, Inc.

Dawn F. McDonald

299 Frederick Rd. Baltimore, MD 21228

Approximate Interval Between Onset and Death

Cremation Society of Maryland, Inc.

299 Frederick Rd. Baltimore, MD 21228

Approximate Interval Between Onset and Death **Physician** a Gram Negative Sepsis
Due to (or as e consequence of): /Medical Immediete Cause (Final disease or condition resulting in death) Examiner Examiner Year S Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last physician s the buriel P.O. Box 68760. Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown Diabetes mellitus à 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy Hyperten sion

The law requires that the death certificate be executed ate has been signed by page 2 should be detec Records, Division of Vital

Completed 1 Natural 2 Accident 3 Suicide 4 ☐ Homicide

29a. Cartifier

Be Certification: To

To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director. Medical

State Registrar 25. Was case referred to medical 1 Yes 2 No 27. Mannar of Deeth

5 Pending investigation

6 Could not be datarmined

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, (arm, street, fectory, offica building, etc. (Specify)

28b. Time of

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

1 Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

1 Certifying Phyalcian: To the best of my knowladga, daath occurred at the time, date end place, and due to the ceusa(s) and mennar as stated.
2 Medical Examiner: On tha basis of examination and/or investigation, in my opinion, daath occurred at tha time, date end place, end due to the ceuse(s) and mennar stated. 29b. Signeture end title of cartifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Nama end eddress of person who completed cause of daath (Item 23a) (Type, Print) Tower

Shannon Putman mo

32 Registrar's Signature 31. Data filed (Month, Dey, Year) SEP 0 9 1997



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 5 Septem 4b. City, Town, or Location of Death **Physician** ame5 /Medical 4a. Facility Name (If not institution, give street end number) **Examiner** U FIMBRE If Under 24 Hrs. SOFTAL Age (In yrs. lest birthday) Paryland Social Security Number Birthplace (Stete or Foreign Country) 218 - 05 - 4287 Usual Residence of Decedent Days Hours Min. 85 Yrs. 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits BALTIMORE 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? Funeral Race - American Indian, Black, White, etc. Armed Forces?. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□Yes 2XNo by 3 □ Widowed 4 □ Divorced Completed 15. Decadent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) CONSTRUCTION 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 20b. Place of Disposition (Neme of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licanse 23e. Part1. Enter the disease, or comshock, or heert failure. List only that druind the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Immediete Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 3 Probably 4 Unknown 1 Yas 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. injury at Work? 27. Megner of Death 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending

ettending physician and for use as the buriel-transit The law requires thet the death certificate be executed Box 68760. Records, P.O. certificate Division of Vital To the Hospital or Attanding Physician: within 24 hours efter deeth. After To the Funeral Director: Af

Funeral

Director

28a-f ahow

ò

"natural", or items 23a

Injury or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 end 2 should be filed within 72 hours effer c Depertment of Health end Mental Hygiene. Important: if item 27 la marked other than "natural", or ham

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

the Maryland

State Registrar

29d. Date signed (Month, Day, Yeer) who completed cause of deeth (Item 23e) (Type, Print)

Placa of injury - At home, farm, street, factory, offica building, etc. (Specify)

Investigation

6 Could not be determined

2 Accident

3 Sulcide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and title of cartifier

1 Yes

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 No

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

DHMH 16 Rev 6/95

Land Committee Street, and

REED

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

| WHITE | State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. | 2 | 7 | 3 | l ₁ | |
|--|--|---|------|------|----------------|----|
| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death | | 3. 7 | Time | of | De |

Physician /Medical

MARGARET HOWE WHITE

4a. Facility Nama (If not institution, give street end number) **Examiner** 601 BRIGHTWOOD CLUB ROAD

MARGARET

SEPTEMBER 5, 1997 4b. City. Town, or Location of Death

3. Time of Death 11:00 AM

Funeral

5. Social Security Number 021-26-6577 Usuel Residence of Decedent

7. Age (In yrs. last birthday) 1□ MX2X F Yrs. 72

REED

LUTHERVILLE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dev. Year)

BALTIMORE

4c. County of Death

Director

with the Maryland

death Hems

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"natural",

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marked other

Pages 1 and 2 should be fit thent of Health and Mental Htant: If then 27 Is marked oth

Ele Ele

traumatic

other or othe

Department of Important: If any injury or

Physician /Medical

Examiner

The law requires that the death certificata be axed

Box 68760.

P.O.

Records,

of Vital

Division

or Attending Physician:

Examiner

Physician/Medical

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Completed

Certification: To

Medical

State

Registrar

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page 2 should

director Be

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Affar

death.

after death filled in by the

To the Hospital of within 24 hours at To the Funeral D completaly filled Hospital

filed within 72 hours after

21215-0020

altimore, Maryland

10a. State MD.

10b. County BALTIMORE

HOWE

10c. City, Town or Location

10f. Zip Code

Months

 Birthplace (State or Foreign Country) 12-08-1924 MASSACHUSETTS

10d. Inside City Limits

show a 23a or 28a-f show Director

Funeral

p

Completed

Be

LUTHERVILLE

21093

Days

1 Yes XXNo 10g. Citizan of What Country?

10e. Street and Number

601 BRIGHTWOOD 11. Marital Status

CLUB DRIVE 12. Was Decedant Ever in U,S. Armed Forces?

1 Yes XXNo
If Yes, Give

College (1-4or 5+)

Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.)

U.S.A. 14. Race - American Indian, Black, Whita, atc.

Specify: WHITE

1 Never Married X Married 3 Widowed 4 Divorced

Year or Dates 15. Decedent's Education (Specify only highest grede completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

1 ☐ Yes XX No Specify:

16b. Kind of Business/Industry

Elementery/Secondary (0-12) 12 YEARS

17. Father's Name (First, Middle, Last)

HOUSEWIFE 18. Mother's Name (First, Middle, Maiden Sumeme)

OWN HOME

WILLIAM

FRANCIS HOWE

MARGARET ALLEN

19a. Informent's Name/Relationship (Type, Print) WILLIAM L.REED (HUSBAND)

20b. Placa of Disposition (Name of cemetery, cremetory or other place)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 601 BRIGHTWOOD CLUB DR., LUTHERVILLE, MD. 20c. Location - City or Town, State

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation X3X Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

OLD NORTH CEMETERY

9-13-97 NANTUCKET, MASS.

21. Signature of Funerel Senior Licensee

ul

22. Name and Address of Facility
HENRY W.JENKINS AND SONS COMPANY 4905 YORK ROAD, BALTIMORE, MARYLAND, 21212 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Finel disease or condition resulting in death)

(or as a consequence of)

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the causa of death? 2 No

1 Yes

3 Probably 4 Unknown

24a. Was en autopsy performed?

24b. Were autopsy findings available prior to completion of cause of deeth?

26. Place of Death (Check only one)

Yes 2 No 27. Manner of Death 1 Naturel

2 Accident
3 Suicide

4 | Homicide

25. Was case referred to medical

5 Pending Investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year) 9-5-97

Ho spital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes

28d. Describe how injury a

28e. Place of Injury - At home, farm, building, etc. (Speaity) LTOME

281 end Number or Rurel Route Number

29a. Certifier

1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated. 29c. License number 29d. Date signed (Month, Day, Yaar)

29b. Signal re and title of certifier

OCME:

SEPTEMBER 06,1997

and address of person who completed cause of death (Item 23a) (Type, Print) Afon weke MD 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

SEP 0 9 1997

32. Registrer's Signature he Javidson-Randelle

DHMH 16 Ray 6/95

Svy Subs-

State of Maryland / Department of Health and Mental Hygiene

7 27346

Item12 9-9-97 FilmG751 W.H.Per F/H Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Year Adele A. Resnikoff September 3 1997 340 am /Medical 4e. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Baltimore Sinai N/A Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AUG - 4, 1914 6 Sex 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□ M 2□€ Days Hours Yrs. MARYLAND 215-46-5556 83 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE MD OWINGS MILLS XX Yes 2 No Director mast be notified 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4601 SPRINGWATER CT., APT. A-1 21117 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 Tables 2 M No If Yas, Give V Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: WHITE þ 3℃ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grada completed) 16e. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME Sattimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Pages 1 and 2 should be !!! ment of Health and Mental H ant: If item 27 is marked off ABRAMS ABE DORA FRIED 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4601 TALMAN RD. BALTO., MD 21208 MRS. DONNA BELSKY (DAUG.) 20b. Place of Disposition (Name of cametary, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removel from State b ARLINGTON (CHIZUK AMUNO) 9/5/97 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice 22 SOL LEVINSON BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one causa on each lina. Onset and Deeth **Physician** /Medical immediate Cause (Final diseese or condition resulting in death) Examiner Examiner Accident erebrovasculer -trans and Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in daath) Lest Dua to (or as a consequence of) physician a Atrial Fibrillation Physician/Medical Due to (or as e consequence of) USB 88 Por signed by the e Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown hypertension PY 24b. Ware autopsy tindings available prior to complation of cause of daath? 24a. Was an autopsy performed? Completed 1 Yas 2 No 1 ☐ Yes 2 No Division of Vital for Attending Physician: after death. Director: After this certified 25. Was case reterred to medical examiner? Be 26. Plece of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28e. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 28a. Place of Injury - At home, ferm, streat, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certitier 🌿 Cartifying Physician: To tha bast of my knowledge, deeth occurred at tha tima, data and place, and dua to tha causa(s) and manner as stated. Medical 2 Medical Examinar: On the basis of axemination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the causa(s) and manner stated. 29b. Signatura and title of certifian 29c. License number 29d. Date signed (Month, Day, Year) A5240232100-9524 September 3 1997 MI) 30. Nama and addrass of person who complated cause of death (Item 23a) (Type, Print) Baltimore Maryland Christopher Davis Hospital Sinai 31. Dete filed (Month, Dey, Year) 2. Registrer's Signatura State SEP 0 9 1997 which Swidson-Randalle Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Lloyd C. Rendina September 01 1997 11:59 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Hospital Leonardtown
If Under 1 Year | If Under 24 Hrs. | 8. De
Months | Days | Hours | Min. | (M St. Mary's Co. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days M 2□ F Yrs 189-36-7209 50 Jan. 30, 1947 Pennsylvania Usual Residenca of Dacedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 42838-A Higgs Lane 20636 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 11. Marital Status 14. Raca - American Indian, Black, White, etc. 1 ☑ Yas 2 ☐ No If Yes, Give Year or Datas: 1 Navar Married 2 T Married 1 ☐ Yes 2 2 No Specify: p Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Gas Station Attendant **AMOGO** 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Be Lloyd Rendina Isabelle Newcomer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle M. Anderson (Daughter) P. O. Box 1139, Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cramation 3 Removal from State Quantico National 4 ☐ Donation 5 ☐ Other (Specify) 9/5/97 Triangle, VA 22. Name and Address of Facility Murphy Falls Church Funeral Home 21. Signature of Pyneral Service License 2000 1102 W. Broad St., Falls Church, VA 22046 ant) enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immadiate Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2010 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? 2/X/No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Nopatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Hatural 5 Pending investigation 1 | Yes 2 | No 2 Accident 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) edica 29a, Certifier 296 Signifuge and time of certify 29d. Data signad (Monthy Day, Year) 29c. Licansa number D-31952 30. Name and addrass of person who complete se of death (Item 23a) (Type, Print)

BRENTON MEDICAL GROUP CALIFORINA, MD. 20619

State Registrar

MICHAEL SZKNOTICKI

31. Date filed (Month, Day, Year) SEP 0 9 1997

M.D

legistrar's Signature

Ma Savidson-Randoll

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Funeral

Director

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the Ms

Department of Heath and Alertal Hy important: if Item 27 is marked other part lightly or other transmitted other parts.

Physician /Medical

Examiner

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physician

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been signed be should be dete

page 2

director.

this funeral

Affer

To the Hospital or Attending within 24 hours effer deeth. To the Funeral Director: Affe completely filled in by the fune

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lew requires that the death certificate be executed

Attending Physician:

of

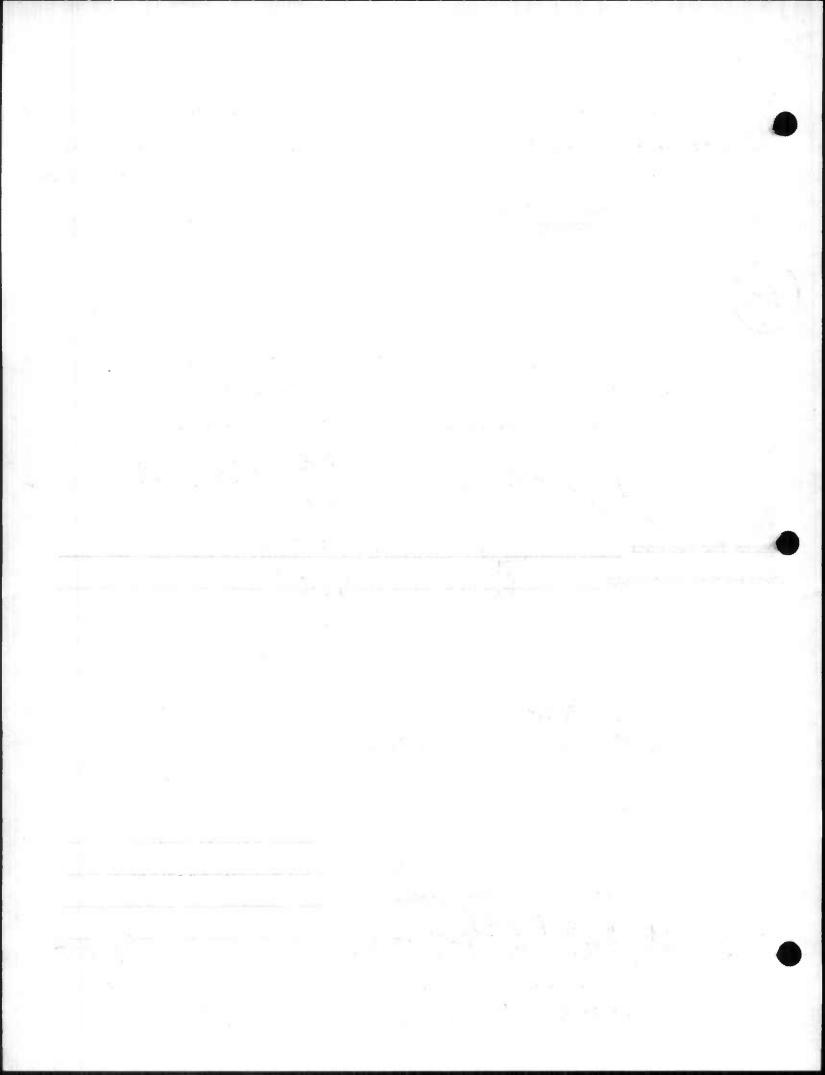
Division

Vital Records, P.O. Box 68760,

LLOYD RENDINA

8 MSLbs 23a

Baltimore, Maryland 2121



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Deeth 3. Tima of Death Day **Physician** Month FRANCIS EARL RICH AUG 27 1997 8:50 AM /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Yeer If Under 24 Hrs. Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1∭M 2□F 78 426-78-1221 Director MAR. 8, 1919 KILN, MS Usual Rasidence of Decedant 10a Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Directo **FAIRFAX** GREAT FALLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11610 AIRVIEW LANE 22066 U.S.A. Funeral 12. Wes Dacedant Evar In U.S. Amed Forcas? YOX/as 2 □ No NAVY if Yes, Give Yeer or Datas: 1941-1963 Wes Decedent of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indien, Bleck, Whita, etc. 11. Maritai Stetus 1 Never Married 2 Married 1 Yas 2XXVo Specify: Specify: WHITE Š 3 ☐ Widowad 4 ☐ Divorced Completed fraumatic event, the Medical 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highast grade complated) Eiementary/Secondary (0-12) Collaga (1-4or 5+) 5+ EXECUTIVE VICE PRESIDENT COMPUTER SOFTWARE 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) 2 should be fit and Mental H Be marked JOSEPH CARL RICH NELLIE LAVANDER RICH 19a. informant's Name/Ralationship (Typa, Pnint) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda) permit. Pages 1 and 2 at Department of Health and Important: If Item 27 is n any injury or other traum ELIZABETH H. RICH WIFE 11610 AIRVIEW LANE, GREAT FALLS, VA 22066 20b. Place of Disposition (Name of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from Stata ARLINGION NATIONAL CEMEIFRY 4 ☐ Donetlon 5 ☐ Othar (Spacify) 9/2/97 ARLINGION, VIRGINIA 22. Nama and Address of Fecility GREEN FUNERAL HOME, INC 721 ELDEN STREET, HERNDON, VA 20170 plicetions that caused tha death. Do not enter tha mode of dying, such as cardiec or respiretory errest, one cause on each line. 1. Entar tha diseasa, ck, or haart failure. L Approximate interval Batwe Onset end Death Physician /Medical immediata Causa (Final disaasa or condition resulting in daath) ADENOCARCINOMA OF THE PANCREAS Examiner Due to (or as a consequance of): Examiner sician end burial-trensit Sequentially list conditions, if eny, laeding to immadiata cause. Entar Undarlying Causa (Disaasa or injury that initiated evants Due to (or as a consaguanca of): physician s the burial Physician/Medical that initiated evants rasulting in death) Last Dua to (or as a consequenca of) 98 signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed complation of causa of death? 1 ☐ Yas 2 X No 1 Yas 2 No director 25. Was casa rafarrad to medical examinar? 26. Placa of Death (Check only ona) Hospitai: 1 Yas 2N No Othar: 4 Nursing Homa 5 Residanca 6 Othar (Specify) 1 inpatient 2 ☐ ER/Outpatiant 3 ☐ DOA funeral 28a. Data of injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28d. Dascribe how Injury occurred Certification: 28c. injury at Work? or Attending Fafter death.

Director: After After 5 Pending invastigation 1 X Naturai 1 TYas 2 No 2 Accidant 6 Could not ba 3 Sulcida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Piaca of injury - At home, farm, straet, fectory, office building, atc. (Specify) 4 T Homicida To the Hospital of within 24 hours a To the Funeral D 29a. Cartifian 1 🖄 Certifying Physician: To tha best of my knowladge, daath occurred at tha tima, data and placa, and dua to tha cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signatura and titia of cartifiar 29c. Licansa numbar 29d. Data signed (Month, Day, Yaar) RES-000

State

Baltimore, Maryland 21215-002

Box 68760

P.O.

Records.

Division of Vital

31. Data filed (Month, Day, Year)

SEP 0 9 1997

J.L.CROOK, LT, MC, USN

32. Registrar's Signatura Jelia Tavidson-Rendom

rass of person who completed causa of death (10 m 23a) (Typa, Print)

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD

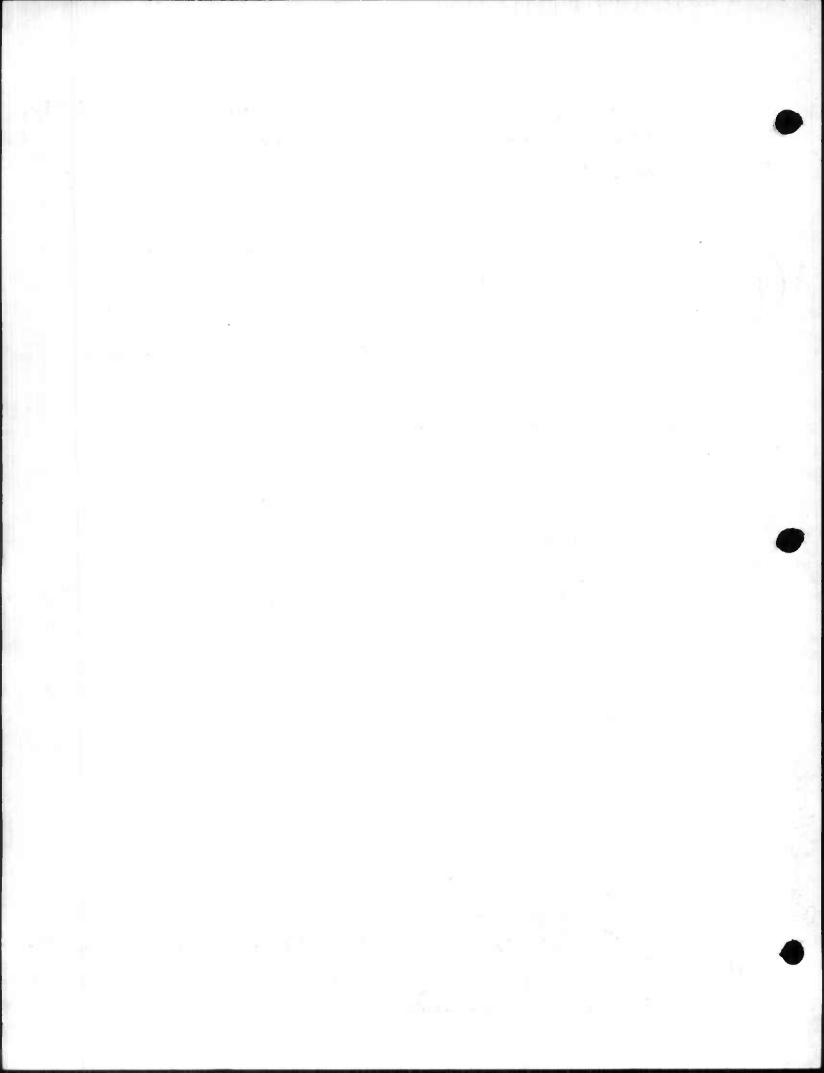
20889-5600

Registrar **DHMH 16 Rev 6/95**

State of Maryland / Department of Health and Mental Hygiene

| | | | | Tar y larr | | ificate of | Death | | Reg. No. | 9/ | 27349 |
|--|----------------------|---|---|---------------------|------------------------|---|--|---------------------------------|------------------------------------|---------------------------|--|
| Physicia | an | Decedent's Neme (First, Middle, La. DODDON | • | | | | | 2. Date of De Month | eth Dey | Yeer | 3. Time of Death |
| /Medic | al | HENRY ROBERT 4e. Fecility Neme (If not institution, give | | and a | | | 4b. City, Town, or Lo | September | | 97 | 4:01 PM |
| Examin | er | UNION MEMORIA | E CITY | | | | | | | | |
| Funeral | | 5. Sociei Security Number 6. S | ex 7. A | Age (In yrs. le | est birthdey) | If Under 1 Year Months Deys | | 8. Dete of Bir (Month, De | N/ | | lece (State or Foreign try) |
| Director | | 251-66-5430 1. Usuei Residence of Decedent | M 2□F | JULY 4 | | | CAROLINA | | | | |
| nylan I m | _ | 10e. Stete 10b. County | | 10c. City | , Town or Loca | tion | | | | 1 | Od. Inside City Limits |
| the Maryia r 28a-f show notified at | Director | MARYLAND N/A | | | BALTI | MORE CI | TY | | | | 1 Yes 2 No |
| 1 0 8 | | 10e. Street end Number 3018 KENTUCKY A | VENUE | | | 10f. Zip Code 2121 | 3 | | 10g. Citizen of V | | try? |
| | by Funeral | 11. Maritel Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced | 12. Was Deceden Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give X Yeer or Detes | No | | es Decedent of F 'es, specify Cubo | fispenic Origin? (Spe en, Mexican, Puerto Specify: | ecity Yes or No Ricen, etc.) | 14. Rac Blee Specify | ck, White, | etc. |
| | Completed by | 15. Decedent's Ed | ucation | · T | | | petion | | 16b. Kind of B | NEG usiness/inc | |
| 21215 od within 7 giene. or then 'n | ple | (Specify only highest gra | de compieted) College (1-4or | r 5+) | | | petion during most of worki d) | ing | | | |
| 21 ad w | Con | 6TH | N/A | | CEMEN | T FINIS | HER | | CONSTRU | CTION | co. |
| N S II S | Be | 17. Fether's Neme (First, Middle, Lest) H.B.ROBERTS | | | | | 18. Mother's Neme | | | ne) | |
| hould Market | Lo | 19e. Informent's Neme/Reletionship (7 | San Deiall | | 405 44-17 | | BESSIE | | | | - |
| | | CORA ROBERTS - | WIFE | | | | end Number or Rura | | | | Code) |
| Baltimore, Meemil. Pages 1 and Popertraint of Health Important: If Item 27 my injury or other trees. | | 20e. Method of Disposition | WILE | 20b. Ple | ace of Disposit | ion (Neme of | Y AVE. BAI | Dete MD | 2121. 20c. Location - | | wn, Stete |
| Pages mt: # if | | 1 Sp Buriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify | Removel from State | Θ | | tory or other plea | | | | | |
| altim mit. Pa partimen portant: y injury | | 21. Signeture of Funeral Service Licen | | 7 | 22.1 | lame end Addre | | | BALTO. | 00,_1 | MD. |
| B Populario | | 1 (celuminos) | Axiso | ask | C | ALVIN B. | . SCRUGGS | FUNERA | L HOME | | |
| | | 23a. Pert1. Enter the disease, or comp shock, or heart feilure. List only | plicetions thet cause | ed/ine death. | Do not enter | the mode of dylr | rg, such es cerdiec o | r respiretory a | rest, | 2121 | Approximete Intervei Between |
| Physician | | | Λ | ^ | 0 | | 0 1 | 1 | | 1 | Onset end Deeth |
| /Medical Examiner | | Immediate Ceuse (Finel disease or condition resulting in death) | · Mul | rip | es e conseque | orgar | · lait | ure | | | 3 Days |
| 1 | ē | Toolan y | | Due to (or | es e conseque | noted): | | | | | 1 |
| Den uted | Examiner | | o. Sep. | | <u> </u> | 1 | | | | | 11 days |
| axectan and training | | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | 12 | | es e conseque | nce or): | | | | 1 | |
| 68760, rifficate be avecuted ng physician and as the bundi-transit | edicai | Ceuse (Diseese or injury thet initiated events resulting in deeth) Lest | . Bow | | 1 SCN es e conseque | evn 10 | | | | 1 | 12 Days. |
| \$ 0 a | ~ | resulting in deeth) Lest | | , | | , | | | | | |
| 30) Ith ce or use | an | | d | | | | | | | 1 | |
| O des | Physician/ | Pert ii. Other significant conditione co | ntributing to death I | but not result | ting in the und | ertylng ceuse giv | en in Pert I. | 23b. Did 1 | obacco use co | ntribute to | the cause of death? |
| ds, P.O. Box ires that the death cer signed by the attendin d be detached for use | by Ph | Adenocarcino | ma of | the | ston | nach | | 10 | 700 2 PM0 | 3 Prob | ably 4□Unknown |
| aw requ | Completed | | | | | | | 24e. Wes perto | en eutopsy med? | ava | re eutopsy findings ileble prior to apletion of cause eeth? |
| Tha Tha page | 000 | | | | | | | 180 | 'es 2□No | 1□ | Yas 2 No |
| of Vital Reconsists of Vit | e B | 25. Was cese referred to medicel exeminer? | | | | | 26. Place of Deeth | (Check only o | ne) | | |
| of of of this all dire | 2 | 1 ☐ Yes 2 No 27. Menner of Death | | | R/Outpetlent | 3□ DOA Oth | 4 Li Nursing Hon | | | |) |
| on o on o ding Phy Afrar this funarral | 5 | 1 Maturei 5 ☐ Pending | 28a. Dete of injuided (Month, De | ey Year) | 8b. Time of injury | 28c. injun World | y et k? Yes 2 □ No | 28d. Describe h | ow injury occur | red | |
| Division or Attending after death. Director: After lin by the fune | | E C T TOURSON | 28e. Piece of in | niury - At hom | e ferm street | | | Paf Location (S | treet end Numb | er or Rural | Route Number |
| Die grand | ficati | 3 ☐ Sulcide 6 ☐ Could not be | | c. (Specify) | -07 1011117 01100 | , | | City or Tow | n, Stete) | or or reares. | riodio ridinoor, |
| | ertificati | 3 ☐ Sulcide 6 ☐ Could not be determined | building, e | | | | | | | | |
| Hospita 24 hours Funeral lataly fille | dical Certification: | 4 Homicide determined 29e. Certifier 1 Certifying Phy | building, e | of exeminetic | edge, deeth o | curred et the tim tigation, in my op | ne, dete end piece, e pinion, deeth occurre | and due to the o | eause(s) end ma date end plece, | nner as sta and due to | ated. the ceuse(s) |
| Divi | Medical Certificati | 4 Homloide determined 29e. Certifier (Check only 2 Medical Exam) | elclan: To the best | of exeminetic | edge, deeth o | tigation, in my o | pinion, deeth occurre | ed et the time, o | date end plece, | and due to | the ceuse(s) |
| Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director. | edicai | 4 Homicide determined 29e. Certifier (Check only one) 1 Certifying Phy one) | elclan: To the best | of exeminetic | edge, deeth o | tigation, in my o | pinion, deeth occurre | ed et the time, o | date end plece, | and due to | the ceuse(s) |
| To the Hospita within 24 hours To the Funeral completely filled | edicai | 4 Homicide determined 29e. Certifier (Check only one) 1 Certifying Phy one) | elclan: To the best nar: On the basis of end menner s | or exeminetic tated | n end/or inves | 29c. Licenso | e number | ed et the time, o | 29d. Date signed | hen, | oy, Year) |
| To the Hospita within 24 hours To the Funeral completely fille | edicai | 4 Homicide determined 29e. Certifier (Check only one) 29b. Signeture end title of certifier | building, e elclan: To the best nar: On the basis of end menner si pompleted ceuse of or | or exeminetic tated | 23a) (Type, Pri | 29c. Licenso | e number | ed et the time, o | 29d. Date signed | hen, | the ceuse(s) |

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Death 3 Time of Deeth Month Physician ichar Radclit AUGUST 24,1997 6:18 a /Medical 4e. Fecility Neme (If not Institution, give street and number) b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY
If Under 24 Hrs. 8, Dete of E Baltimore City 8. Dete of Birth (Month, Dey, Yeer) Nov. 17, 1925 5. Sociel Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthdey) 9. Birthplece (State or Foreign Country) Kansas Funeral 1₩ M 2□ F Months Deys Hours Min 515-14-9540 Yrs. 71 Director Usuel Residence of Decadent deeth with the Maryland 10e Stete 10b. County show 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Expression must be notified at 1 Yes 2√ No Funeral Director Montgomery Silver Spring Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1309 Gresham Road 20904 U.S.A. 11 Marital Status 12. Was Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. filed within 72 hours efter X Yes 2 No Yes, Give 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Hygiene. 12 Right/Way Agent L Pages 1 and 2 should be filed with the state of Health and Mantal Hygier transit: if item 27 is marked other thinty or other traumatic event, in Private 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be B. Ellsworth Radcliffe Helen Regina Olson 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Lois A Radcliffe - wife 1309 Gresham Road, Silver Spring, Maryland 20904 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State Department of Important: H any injury or once. 4 ☑ Donetion 5 ☐ Other (Specify) 21. Signature of Fineral Service Licensee Ronald S. 22. Name end Address of Fecility State Anatomy Board, 655 W. Baltimore Street Wade, Director Baltimore, Maryland 21201 Pert 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, hock, or hear feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) **Examiner** Examiner 1150m's The law requires that the death certificate be executed the burief-transit pue Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of) Box 68760 Physician/Medicai Due to (or es e consequence of): USB BSU P.O. Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 2 8 No 3 Probably 4 Unknown Division of Vital Records, by 90 24b. Were eutopsy findings eveileble prior to Completed 24e. Wes an eutopsy completion of cause of deeth? 1 ☐ Yes 2 XNo

director, page 2 should certificate Hospital or Attending Physician: this funeral After death. efter death

Be

Certification: To

Medical

25. Wes case referred to medical exeminer? 1 Yes 2 No

Neturel

3 Suicide

29e. Certifier

2 ☐ Accident

4 ☐ Homicide

27. Menger of Deeth 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Dey Year) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

1 Inpatient 2 ER/Outpetient 3 DOA

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29b. Signature and title of certific

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pieca, and due to the ceuse(s) end menner es steled.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end piaca, and due to the cause(s) end manner stated. 29d. Dete signed (Month, Day, Year) 29c. License number

26. Plece of Deeth (Check only one)

Res-000

prieted cause of deeth (Hem 23e) (Type, Print)

Report of Baltimore, Maryland

State Registrar

filled in by

To the Hospital within 24 hours e

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Dale of Deeth 3. Time of Death Month **Physician** Rudol Marion 1097 Aug /Medical 4e. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death cf Balture If Under 24 Hrs. 8. Dete Iniversity Medical Cyaler birthday) If Under 1 Year Man 1 and Baltimore City 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 1 M 2□ F Months Days Hours 69 217-26-5489 Yrs. June 10, 1928 West Virginia Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland unknown 1 ☐ Yes 2 ☐ No Director unknown unknown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? unknown Funeral unknown U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ⊆ ☑ No If Yes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Marital Stetus 1 Nevar Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done di lifa. DO NOT use retired) during most of working Elementary/Secondary (0-12) Collega (1-4or 5+) Construction Laborer 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lacey Von Rudd Mattie Ellen Rigsby 19a. informant's Name/Rafationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Roger Cutlip/ nephew 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other placa) Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □Other (Specify) in state 21. Signature of Funeral Service Licensee Ronald S. Wade Director 22. Neme end Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

23a. Plut. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiretory errest, shock, or haart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediata Causa (Final 23 days disease or condition resulting in death) Physician/Medical Examiner Bowe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events rasulting in death) Lest Due to (or as a consequence of) Bowe Obstruction Mall Due to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part i. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Hakmown þ 24b. Were autopsy findings available prior to completion of causa of death? Be Completed 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 25. Was casa rafarrad to medical 26. Place of Death (Check only ona) 1 Yes No Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stata)

Certifying Physician: To the best of my knowledge, daath occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and dua to the causa(s) and manner slated.

29c. License number

Baltimore MD 21201

29d. Date signed (Month, Day, Year)

Records, P.O. Box 68760, The law requires that the death certificete be Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p

Funeral

Director

r than "naturel", or items 23s or 28s-f ehow the Medical Examiner trust be notified at

the Meryland

filed within 72 hours efter deeth with

pemit. Pages 1 end 2 should be filed wir Department of Heelth and Mental Hygiens Important: If Item 27 Ie marked other tha any Injury or other traumatic event, Item. 2002.

Physician /Medical

Examiner

physician and s the burial-transit

ettending p 62

signed by the eld be detached to

certificate has been si rector, page 2 should

Baltimore, Maryland 21215-0020

State Registrar

Medicai

South 31. Date filed (Month, Day, Year) 0 9 1997

29b. Signature and title of cartifier

4 Homicide

29a. Cartifier

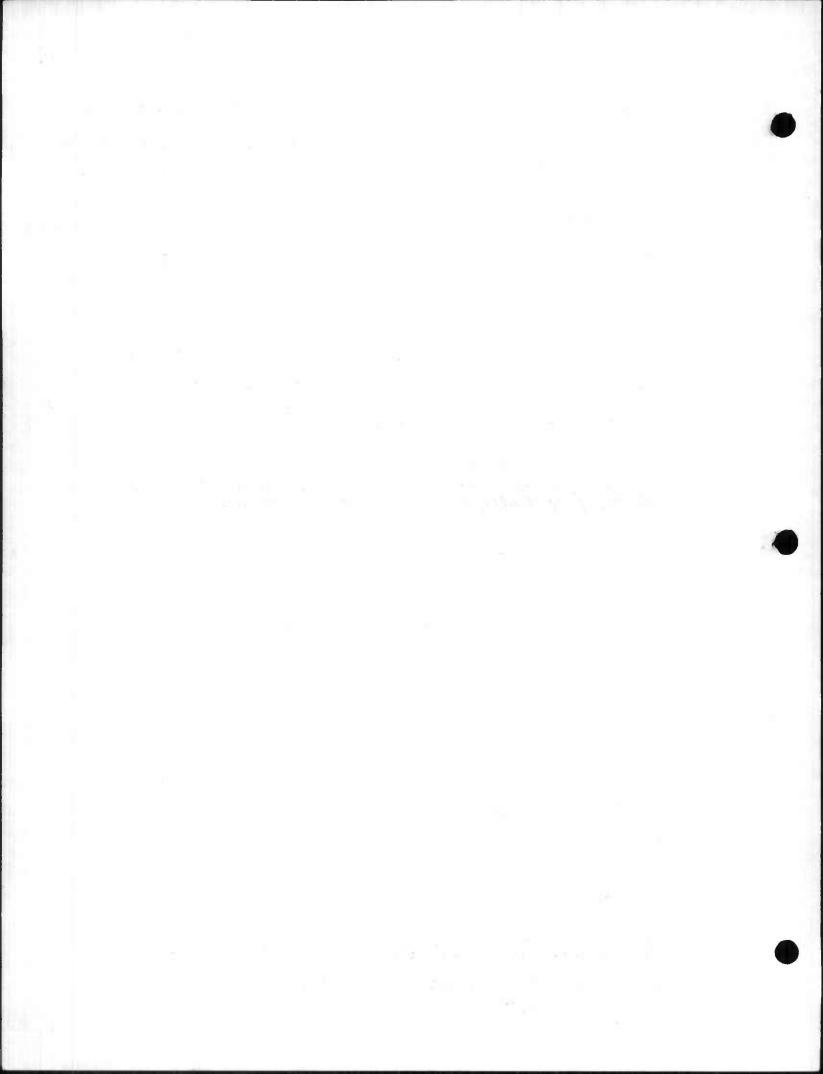
32. Registrar's Signature

rreene

Street,

30. Nama and address of person who complated causa of daath (Item 23a) (Type, Print)

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

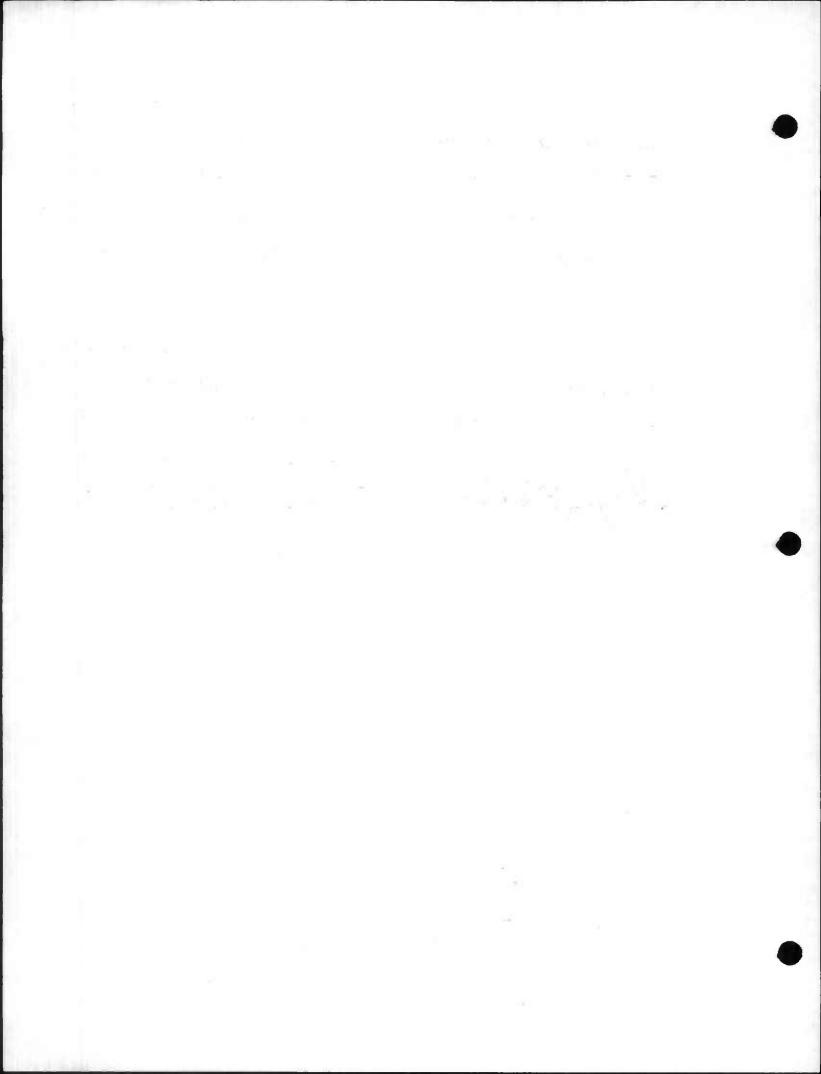
State of Maryland / Department of Health and Mental Hygiene 9.7. 2.7.3.5.2

| | | | | | | Certificate of | | | Reg. No. | (| 1002 | | |
|---|----------------------------------|---------------------|--|--|-------------------------------|---|---|---|---|--|--|--|--|
| | ysici: Medic | | Decedent's Name (First, Middle, Las | | rroll | Smi | th | 2. Date of De Month Septe | ember 7, | 1997 | 3. Time of Death 6:00 AM | | |
| | kamin | | 4a. Facility Name (If not Institution, give Genesis Elderco | | | | | or Location of Deal | h 4c. County | | re | | |
| | neral ictor | | 5. Social Security Number 6. St 217-01-3427 Usual Residence of Decedent | TIM OFF | ge (In yrs. last birt 93 | hday) If Under 1 Ye Months Day | | in. 8. Date of Bi | 1, 1903 | 9. Birthplace (State or Forei Country) Indiana | | | |
| Manyland H ehow | fledat | tor | 10a. State 10b. County | ltimore | 10c. City, Towr | or Location | 1 | 0d. Inside City Limits | | | | | |
| h with the | at be not | Funeral Director | 10e. Street and Number 1743 Stokesly Ros | ıd | | 10f. Zip Code | 2122 | 2 | 10g. Citizen of Whet Country? United States | | | | |
| D-UUZU 72 hours efter death with the Maryland naturel, or items 23e or 28s-f ehow | Examinet must be notified at | þ | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedan Armed Forces 1 Yes 2 X If Yes, Give Year or Dates: | ? | Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexicen, Puerl □ Yes 2 ☒ No Specify: | | (Specify Yas or No erto Rican, etc.) | 14. Rac Blac Specify | Race - Amarican Indian, Black, White, etc. | | | |
| within ene. | the Medical | Completed | 15. Decedent's Ed (Specify only highest gre- Elementery/Secondary (0-12) | ucation da completed) College (1-4or | life. DO NOT use retired) | | | | | | Susiness/Industry L Industry | | |
| aryland should be filed and Mental Hygi merked other | | To Be C | 17. Father's Name (First, Middle, Last) William A. Smith | | | | 18. Mother's N | lame (First, Middle Evang | Maiden Suman | , | | | |
| | trau | | 19e. Informant's Name/Relationship (7 Wrs. Nancy Phelps | | | Mailing Address (Stre 743 Stokes | | | | | Code) 1222 | | |
| _ 0 | ry or other | | 20a. Method of Disposition 1 ☐ Burial 2 【☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify | | cemeter | Disposition (Neme of y, crematory or other p | , | Date / 9 / 1997 | 20c. Location - | | | | |
| permit. Page Department of Important: If | eny inju | | 21. Signature of Juneral Service Licen | tress of Facility. R Funera | l Home of Dundalk, | S Dundal | k, In | 222 | | | | | |
| Physic /Med Exam | lical | | 23e. Part1. Enter the sease of companies only of limited and the limited and l | ilications that causa one cause on each | | D SC | lying, such as cerd | liac or respiratory a | rrest, | | Approximete Interval Between Onset and Death | | |
| tificate be executed g physician end | es the burlei-transit | edicai Examiner | Sequentially list conditions, if eny, leading to immediate causa. Enter Underlying Ceuse (Diseese or Injury thet initiated events rasulting in death) Last | b | Due to (or es a c | onsequence of): | | | | | | | |
| | | d. | | | | | | | | | | | |
| that the de | 0 | y Physician/M | Part II. Other significant conditions co | ntributing to death I | out not rasulting In | the underlying ceusa | givan in Part I. | | 23b. Did tobecco use contribute to | | | | |
| aw requir | | Completed by | | | | | | 24a. Was | en eutopsy ormed? | cor | ere autopsy tindings ailable prior to applation of causa deeth? | | |
| VICAL DI | tor, pege | 0 | 25. Was cese referred to medical | | | | 26 Place of F | 1 Deeth (Check only | | 10 | Yes 2 No | | |
| this of | ral dire | Certification: To B | 27. Menner Deeth 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be | Hospital: 1 Inpati | ury 28b. T | ime of 28c. In jury | Other: Nursing jury et Vork? | Home 5 Resi | dence 6 Goth | red | | | |
| To the Hospital or within 24 hours afte To the Funeral Dire | completely filled in by the fune | edicai Cert | 29e. Certifier 1 Certifying Phy | sician: To the best | of examination and | death occurred at the | time, date and pla y opinion, death or | City or To | cause(s) and ma | anner as st end due to | ated. the ceuse(s) | | |
| To the within 2 To the | eldmoo | _ | 29b. Signature and Ulier of certifier | and manner st | Trisber | | ensa number 20964 | | 29d. Data signe September | | | | |
| 2 | Stat | | 30. Name and address of person who of Jerome H. Ginsbe. 31. Date flied (Month, Dey, Year) | rg, M.D. | death (Item 23a) (8630 Li | Type, Print) berty Plaz | a Mall I | Randallst | own, MD | 2113 | 3 | | |

DHMH 16 Rav 6/95

Registrar

SEP 0.9 1997



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| MARYLAND 21215-0020 | Dans & may be retained by the hoenits or attending pheiring |
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| | hoen |
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| ALTIMORE, | Done |
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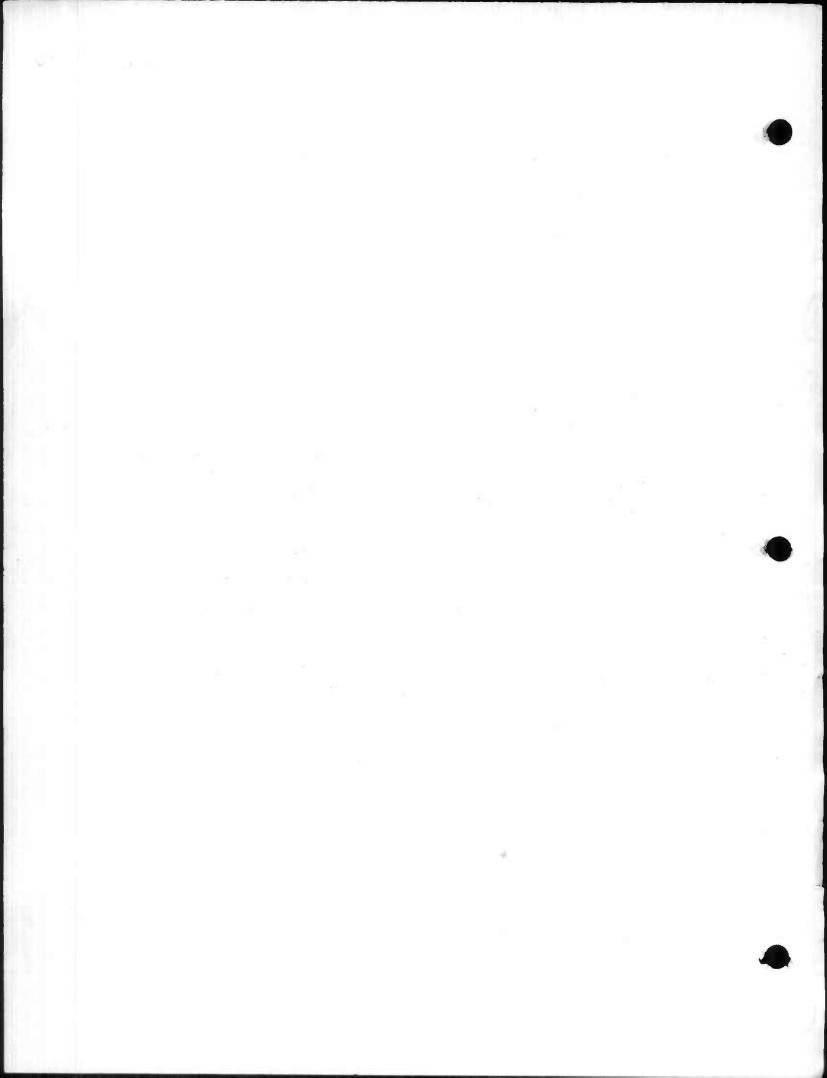
DIVISION OF VITAL RECORDS, P.O. BOX 68760

| AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | ECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should ns after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | PORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|--|--|
| TO THE HOSPITAL OR ATTENDING PHYSIC | TO THE FUNERAL DIRECTOR: After this ce be filed within 72 hours after death with the | IMPORTANT: If item 28 is marked, |

| STATE | 0F | MARYLAND | 1 | DEPARTMENT | 0F | HEALTH | AND | MENTAL | HYGIEN |
|-------|----|----------|---|------------|----|--------|-----|--------|----------|
| | | C | E | RTIFICATE | OI | F DEAT | "H | | REG. NO. |

| | FOR 1 - STATE REGISTRAR | STATE OF MARYLA | | TOF HEALTH AND | MENTAL HYGIEN REG. NO. | E | | | | | | | |
|------------------|--|---|--|--|--|---------------|--|--|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Leet) NARVELL | GCRIVENS | | | 2. DATE OF DEATH DATE SEP 6 | Y /997 | | | | | | | |
| | 01. 0 1 1 201 | XM2DF 5 | 9 YRS. MONTHS | ER 1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN. TY, TOWN OR LOCATION OF DE | 7. DATE OF BIRTH (Month, Day, Year) Feb. 18, 193 | Co | RTHPLACE (State or Foreign unity) | | | | | | |
| CTOR | Church Home | N/4 | | | | | | | | | | | |
| DIRECTOR | MD. 10b. COUNTY | | Bal+ | imore | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | | | | |
| FUNERAL | 2337 McEl | | reet | 21205 | | U.S. | E WHAT COUNTRY? | | | | | | |
| BY FU | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced | FORCES? 1 PYES IF YES, GIVE WAR OR DAT | 2 NO | 3. WAS DECENDENT OF HISPAI If yes, specify Cuban, Mexico 1 YES 2 NO Specif | in, Puerto Rican, etc.) | В | ACE — American Indian, lack, White, atc. Pocify Black | | | | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | | | | | | |
| | 17. FATHER'S NAME (First, Middle, Last) ALDERT SC | ivens | Alcohol | Counselor 18. MOTHER'S NA Alme- | ME (First, Middle, Meiden | | ter Center | | | | | | |
| TO BE | 190. INFORMANT'S NAME (Properties) Wife 1916. MAILING ADDRESS (Street and Number or Rural Route Number, City or Townstreet, Zip Code) Ida B. Scrivens 2337 MC Elderry Street Baltimore, MO. 21205 | | | | | | | | | | | | |
| | 20a, METHOD OF DISPOSITION 1 Burtol 2 Cremation 3 Removed from State 1 Surface AND DATE Cremation 3 Removed from State 1 Surface AND DATE 20c. LOCATION — City or Town, State 1 Surface AND DATE 20c. LOCATION — City or Town, State 2 Sept. 12 O Wings Mills, MO, 21. SIGNATURE OF SURFACE AND DATE 20c. LOCATION — City or Town, State 22. NAME AND ADDRESS OF FACILITY Nutter Tune ral Homes, Inc. | | | | | | | | | | | | |
| | 23. PART I. Enfer the disesses, or con | | | 2501 Gwynn er the mods of dylfig, suc | M | | Approximats | | | | | | |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) Due To (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| NO | Sequentially list conditions, | 12 14 > 6 | | | | | | | | | | | |
| CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | A | CONSEQUENCE OF): LCCHALIC CONSEQUENCE OF): | CARDION | HYOPATHY | | Chronic | | | | | | |
| AL | PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. PENAL FAILURE 24s. WAS AN AUTOPSY PERFORMED? 1 □ YES 2 □ MO | | | | | | | | | | | | |
| PHYSICIAN: MEDIC | DID TOBACCO USE CONTRIE | 2 | F DEATH YES C | | N 🗆 | | 1 YES 2 NO | | | | | | |
| SIC | | OSPITAL: Inpetient 2 ER/Outpe | Itlent 3 DOA 4 N | ER: lursing Home 5 🗆 Residenca | 6 Other (Specify) | | | | | | | | |
| ВУ РНУ | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28s. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 YES 2 NO | 284. DESCRIBE HOW | | | | | | | | |
| | 3 Suicide 6 Could not be determined | building, atc. (Speci | | | 281. LOCATION (Street City or Town, State) | | ral Route Number, | | | | | | |
| COMPLETED | The state of the s | | | e time, date end place, and du- y opinion, death occured at the | | | se(e) end menner es stated, | | | | | | |
| TO BE | 29b. SIGNATURE AND TITLE OF CERTIFIER | oshn: m | | 29c. LICENSE NU | MBER 6594 | 29d. DATE SIG | NED (Month, Day, Year) | | | | | | |
| | 30. NAME AND ADDRESS OF PERSON WHO (R. BOKHARI M. 31. DATE FILED (Month, Day, Year) | D. 100 | N. BRO | ADWAY 1 | BALTIMORU | m D | 21231 | | | | | | |
| | SEP 0 9 1997 | The Davidson-V | fandelle | | | | DHMH-18 Rev 1/89 | | | | | | |





Physician /Medical Examiner **Funeral** Director

1. Decedent's Neme (First, Middle, Last)

r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 2 should be filed within 72 and Mentel Hygiene. 8 marked other than "ne -09 27 6 important: If is any injury or o once.

> **Physician** /Medical

Examiner

slcian end buriel-transit be executed Box 68760. P.O. Records, Division of Vital Mospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical etely filled in by the funerel director.

Month William Albert Shorter 4b. City, Town, or Location | Death | 4c. County of Death 6-00pm 4a. Fecility Nama (If not Institution, give street and number) North Arundel Hospital Glen Burnie Anne Arundel If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth
Mache Dave Hours Min. (Month, Dey, Year) 5. Social Security Number 6. Sax 9. Birthpleca (State or Foreign Country)
1 1 4 Virginia 7. Aga (In yrs. lest birthday) 1**2** M 2□ F 83 229-14-4423 Yrs. Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10b County 10d. Inside City Limits Director 1 ☐ Yas 3 ☐ No Anne Arundel crownsville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1385 Generals Highway 21032 U.S.A. Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxicen, Puarto Rican, atc.) 14. Rece - American Indian, Black, Whita, atc. 1 XYes 2 No If Yes, Give Yeer or Detes: WWII 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: by 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Water Filtration Tech. State of Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meldan Surname) Winburn S. Shorter Lilly Ida Funk 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Edna Hambruch/daughter 8070 Montaque Ct., Glen Burnie, MD 21061 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Ramoval from Stete Glen Haven Cemetery 9/9/97 Glen Burnie, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Addrass of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23e. Pert1. Entar the disease of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. Unit only one cause on each line. Approximate interval Between Immediate Cause (Final · GATTROINTESTINAL BLEED disaase or condition rasulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events rasulting in death) Lest Due to (or as e consequence of): Physician/Medicai Due to (or es e consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? SEPSIS 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evelleble prior to completion of cause of death? 24e. Wes en autopsy performed? CONGETTIVE HEART FAILURI-Completed CAMONIC OBSTRUCTIVE LUNG DISEASE 1 ☐ Yes 20 No Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Tippinpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 9 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 Neturel 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicida 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 4 Homicide edical 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and menner es steled.

2 Madical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) end manner stated. 29e. Certifier (Check only one) 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of certifie SEPTEMBER 6,1997 , M.O. 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) HOSPITAL, MD 2106/ V. BRUCE, NORTH ARUNDEL 31. Dete filed (Month, Dey, Year) 32. Begistrer's Signeture State SEP 0 9 1997 Registrar

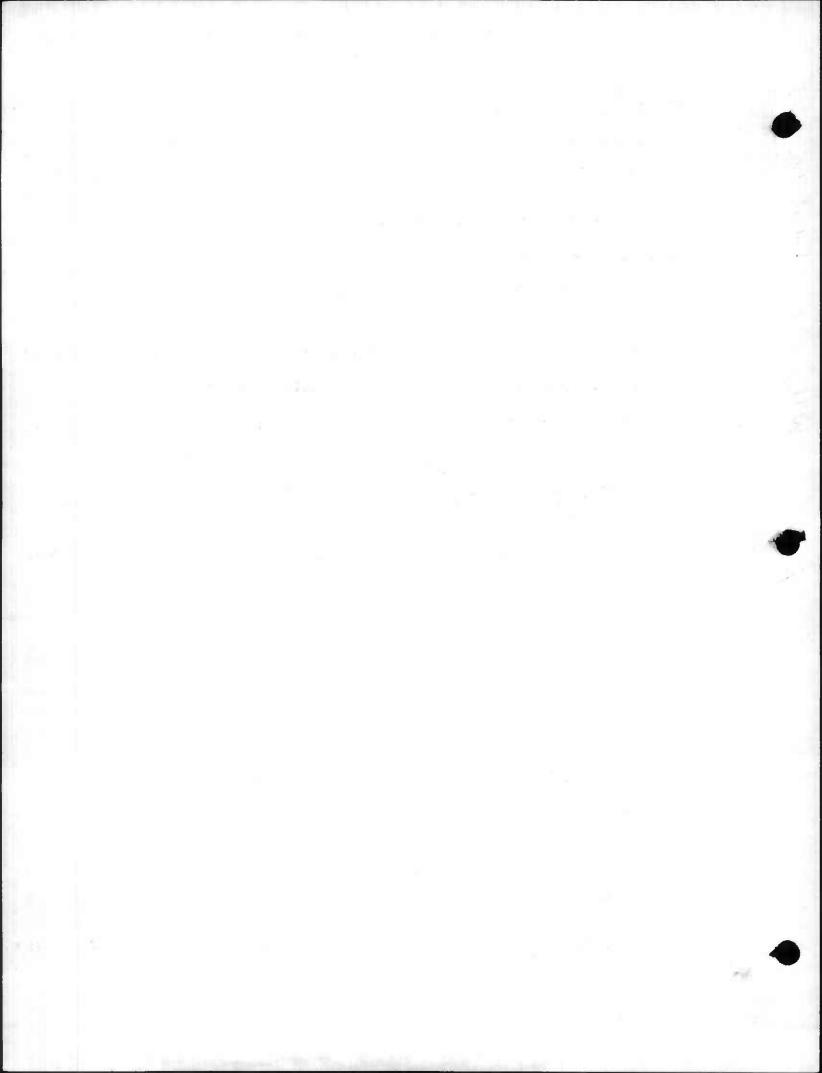
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Dete of Deeth

3. Time of Death

DHMH 16 Ray 6/95

To the Hosp within 24 hor To the Fune completely fi



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Date of Death Month 4b. City, Town, or Local of Death 20 Charles G. Sterner Facility Neme (If not institution, give street and number, 4c. County of Death 6. Sex Baltimore 5. Sociel Secrity Number If Under 1 Yeer 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Date of Birth 1 XM 2 ☐ F Months Days Hours 70 216-20-2128 09/24/1926 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 No 2 No Maryland | Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 413 Chalfonte Drive 21228 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1□ Yes 2□No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: WW II 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Mortgage Banker Banking 4 years 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Russell G. Sterner Mary Ann Smith 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mary Catherine Sterner/Wife 413 Chalfonte Drive Catonsville, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 9/11/97 Sykesville, Maryland Crest Lawn Cemetery 21. Signature of Funeral Segrice Lio 22. Name and Address of Fecility David J. Weber Funeral Home 5311 Edmondson Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart failure. List only one ceuse on each line. Approximate Interval Between secondary to liver Onset and Deeth and hepotitis Immediete Cause (Final years disease or condition resulting in death) Due to (or as e consequence ot): Due to (or as a consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown Mixeate -

Physician /Medical Examiner

the buriel-transit

88

After this certificate

Director

To the Hospital or Att within 24 hours efter of To the Funeral Direct completely filled in by

death.

permit. Pages 1 end 2 should be file Department of Health end Mentel Hy Important: If Item 27 is marked oth any injury or other traumatic evant

Physician

/Medical

Examiner

10e. Stete

Funeral

Director

r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at

Director

Funeral

à

Completed

Be

Examiner

Physician/Medical

þ 90

Completed

Be

2

Medical Certification:

the Maryland

Baltimore, Maryland 21215-0020

Box 68760.

NAME: Sterner, Charles

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

24a. Was an eutopsy performed?

24b. Were autopsy findings evailable prior to completion of cause of death?

1 Yes 2 No 26. Plece of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 ☐ Yes 2 ☐ No

| examiner? | | | |
|------------------|-----------------------|-----------------|--------|
| 1 Yes 2 No | Hospital: 1 Inpatient | 2 ER/Outpatient | 3□ DOA |
| 27. Manner Deeth | 28a. Date of Injury | 28b. Time of | 28c. |

1 Natural 5 Pending Investigation 2 Accident 3 Suicide

(Month, Dey Year) 6 ☐ Could not be

1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28d. Describe how injury occurred 28f. Location (Street end Number or Rural Route Number, City or Town, State)

4 ☐ Homlcide 1 M Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner steted. 29a. Certifier (Check only one)

29b. Signature and title of pertifier

31. Date filed (Month, Dey, Year) SEP 0 9 1007

0 9 1997

OF Man ages referred to medical

29c. License number 706

28c. Injury et Work?

29d. Dete signed (Month, Day, Year)

who completed cause of deeth (Item 23e) (Type, Brint)

32. Registrar's Signature

State Registrar

State of Maryland / Department of Health and Mental Hygiene 27356 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey **Physician** Month Yeer 19, 1997 AUG. 0042 AM Shaffer /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death **Examiner** UNIVERSITY HOSPITAL S.T.U BALTIMORE Baltimore City 7. Aga (In yrs. last birthdey)

H Under 1 Year

H Under 24 Hrs.

Months

Deys

Hours

Min.

Min.

March 28, 1946 5 Social Security Number Birthplaca (Stete or Foreign Country) **Funeral** 1 €M 2 □ F 188-38-3906 Director Pennsylvania Usuef Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at to Yas 2 □ No Director Maryland Baltimore City Baltimore 10e. Street end Number 10f. Zip Code 10a, Citizen of What Country? 21202 U.S.A. 1002 North Calvert Street Funeral 12. Wes Decedant Evar in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, atc.) 14. Race - American Indian, Bleck, White, etc. filed within 72 hours after of Hygiane. Ither than "natural", or item 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ₩ No Specify: Àq Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Education Elementery/Secondary (0-12) College (1-4or 5+) . Pages 1 and 2 should be filed wittness of Health and Mental Hygian tant: If Item 27 is marked other the jury or other traumatic event, the English Teacher Baltimore City School 5+ 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Robert Shaffer Patricia Louise Patton 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 15926 19e. Informent's Neme/Reletionship (Type, Print) Robert Shaffer 1269 Pennisula Drive, Central City, Pennsylvania 20b. Piece of Disposition (Name of cemetery, cremetory or other piece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriei 2 ☐ Cremetion 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 4 □ Donetion 5 □ Other (Specify) in state 21. Signature of Fun rei Sarvice Licensee Ronald S ^{22.} Name end Address of Facility
State Anatomy Board, 655 W. Baltimore Street Wade Director Baltimore, Maryland 21201

Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, or heart failure. List only one cause on each line. Approximate Onset end Death **Physician** /Medical Immediate Cause (Final Multiple injuries disaasa or condition rasulting in death) **Examiner** Examiner The law requires that the death certificate be executed physician and the buriel-trans Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events rasulting in daeth) Lest Due to (or es e consequence of): Physician/Medicai the Due to (or as a consequence of): for use as Pert II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. the 23b. Did tobacco use contribute to the cause of death? 3 1 | Yes 2 | No 3 | Probably 4 | Unknown signed b by 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed peen page 2 1 ¥ Yes 2 □ No certificate To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Be 25. Was cese referred to medicei axeminer? 26. Piece of Deeth (Check only one) Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) XIX Yes 2□ No 27. Menner of Deeth 28e. Dete of injury (Month, Dey Year) 28b. Time of injury 28d. Describe how injury occurred Tall out 28c. Injury et Work? 1 Neturel 5 Pending banisas on fourth flow 1 TYas 2 No 0005 M Investigation 2 Accident 8-19-97 6 Could not be detarmined 3 Suicida 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 1002 Caluart St 28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 - Homicide Appartment Baltamore MD Certifier (Check only one)

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) and menner es steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner steted. 29e. Certifier Medical 29b. Signeture end title of certitier 29c. License number 29d. Dete signed (Month, Dey, Year)

O.C.M.E

111 Penn Street, Baltimore, Maryland 21201

AUG. 23, 1997

Division of Vital

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Records,

30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) DONALD & WRIGHT MD 31. Dete filed (Month, Day, Year)

SEP 0 8 1997



Donald & Wright MO

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled writhin 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| _ | REGISTRAN | | | | <u> </u> | | VAI | | DEA | | | HEG. NO. | | | |
|-------------|--|---------------------------|---------------------------------------|----------------|-------------|-----------|-------------|------------------|---------------|---------------|-------------------------|---------------------|----------------------|------------------|---|
| į | MONTH DAY YEAR O | | | | | | | | | | | | | | 3. TIME OF DEATH |
| | | | | | | | | | | | Aug. | 27, | 1997 | 7 | 8:25 рм |
| | 4. SOCIAL SECURITY NUME | BER | 5. SEX | 6. AGE (In | yrs. lest t | | IF UNDI | DAYS | | MIN. | 7. DATE OF (Month, I | BIRTN Day, Year) | | 8. BIRTH | NPLACE (State or Foreign ry) |
| | 218-74-5427 | | 1 D M 2 👾 | 9 | 91 | YRS. | | | | | May 2 | 9, 19 | 906 | Balt | o. MD |
| | 9a. FACILITY NAME (If not in | | | | | | | | OR LOCAT | 121 | | | 9c. COL | INTY OF C | DEATN |
| 20101 | Maria Healt | .Char | MD 2 | 21212 | 2 | | Ba. | ltimo | re | | | | | | |
| 5 | 10c. CITY, TOWN OR LOCATION 10 | | | | | | | | | | | | | 10d, INSIDE CITY | |
| 5 | MD | Balti | more | | - | | | | | | | | | | LIMITS? |
| | 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHA | | | | | | | | | | | | | | |
| LONEHAL | | | | | | | | | | | | | | | |
| | 11 MARITAL STATUS 12 WAS DECEMENT EVER IN U.S. ARMED 13 WAS DECEMBENT OF NISPANIC ORIGIN? (Specify Van or No. 14. RACE. | | | | | | | | | | | | E — American Indian. | | |
| 2 | FORCES? 1 YES 2 WO If yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, W | | | | | | | | | | | | k, White, atc. | | |
| | 3 ☐ Widowed 4 ☐ Divorced IF YES, GIYE WAR OR DATES TO 1 ☐ YES(\$\frac{1}{2}\) NO Specify: Specify: | | | | | | | | | | | | WILLE | | |
| 2 | | EDENT'S EDU | | | | EDENT'S | | | | | 16b. F | IND OF BU | SINESS/IN | DUSTRY | |
| 4 | Elementary/Secondary (1 | ly highest grade 0-12) | College (1-4 or 5 | +) | life. E | Do NOT us | e retired | e aunng .) | most of work | ing | | | | | |
| 1 | 12 | | 5 + | | M | usic | Te | ache | er | | | olle | ge | | |
| COMPLEIE | 17. FATNER'S NAME (First, A | Aiddle, Last) | | | | | | | 18. MO | NER'S NA | ME (First, Mic | idle, Maiden | Sumame) | | |
| 2 | Hugo Staab Mary Busick Staab | | | | | | | | | | | | 0 | | |
| | 19a. INFORMANT'S NAME (| Type/Print) | | | 19b. | MAJLING | AODRE | SS (Street | et and Numbe | or Or Rural i | Route Number | City or Tow | n, Stete, Z | (ip Code) | |
| E | Hernice Feilinger 6401 N. Charles St. Bal | | | | | | | | | | | | 1212 | | |
| | 20a. METNOD OF DISPOSIT | | oval from State | PLACE AP | ND DATE O | OF DISPO | DSITION | (Nanheo) ashe | S | OATE | 20c. LO | CATION - | - City or To | own, State | |
| | 20a. METNOD OF DISPOSITION 1 Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of a Shes) 20b. PLACE AND DATE OF DISPOSITION (Name of a Shes) 20c. LOCATION — City or Town, cemetary, crematory or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of a Shes) 20c. LOCATION — City or Town, cemetary, crematory or other place) 20c. LOCATION — City or Town, cemetary, crematory or other place) 20c. LOCATION — City or Town, cemetary, crematory or other place) 20c. LOCATION — City or Town, cemetary, crematory or other place) | | | | | | | | | | | | | | |
| | Lonald S. Wade Director 22. Name and Connects of Facility Board, 655 W. Balti | | | | | | | | | | | | | altimore St. | |
| | Baltimore, Maryland 21201 | | | | | | | | | | | | | | |
| | 23. PART I. Enter the o | | | | | th. Do r | not ent | er the i | node of d | ylng, auc | h aa cardi | c or reap | Iratory a | rreat, | Approximate |
| - | shock, or h | | List only one ca | | | 0 | _ | 0 | , | | | | | | Onset and Death |
| | disease or condition | → | · mi | 104 | ud | ich | 0 | Fret | corc | 20 | n | | | | 48 hrs |
| | resulting in death) | | OUE TO | OR AS A | CONSEC | UENCE OF | F): | - () | | | | | | | |
| z | | | b | | | | | U | | | | | | | |
| KIIFICALION | Sequentially list condi- If any, leading to imme | | OUE TO | OR AS A | CONSEC | UENCE O | F): | | | | | | | | |
| 5 | cause. Enter UNDERLY CAUSE (Disease or Injury) | | c | | | | | | | | | | | | |
| = | that initiated events resulting in death) LAS | | OUE TO | OR AS A | CONSEC | UENCE O | F): | | | | | | | | |
| ш | readiting in death) CA. | " | d | | | | | | | | | | | | |
| 5 | PART II. Other signific | ant condition | ns contributing to | deeth bu | t not re | eulting | In the | underly | ing cause | given in | Part I. | 4a. WAS AN | | 24 | b. WERE AUTOPSY FINDINGS |
| 5 | | | | | | | | | | | | PERFO | | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | | | | | | | | | _ | 1 123 | Sey NO | | OF DEATH? 1 YES 2 NO |
| Σ | DID TOBACCO U | ISE CONT | RIBLITE TO CA | ALISE OF | DEAT | H YE | s \square | NO. | MI DE | CERTAI | N D | | | | 1 120 1 110 |
| AN | 25. WAS CASE REFERRED | | I I I I I I I I I I I I I I I I I I I | | | OF DEA | | | | CLIVIA | | | | | |
| SICIA | EXAMINER? X | | HOSPITAL: | ☐ EB/Outna | tlent 3 | DOA | OTH AYD | | lome 5 🗆 I | Pasidanca | 6 🗆 Other | (Specific) | | | |
| Ë | 27. MANNER OF DEATN | | 28a. DATE O | F INJURY | | 28b. TIM | E OF | | TA YRULNI | 18910011100 | | RIBE NOW | INJURY O | CCURED | |
| Z | | Pending | (Month, | Day, Year) | | IN. | JURY | | WORK? YES 2 | □ NO | | | | | |
| 20 | 2 Accident 3 Suicide | Investigation | 28e. PLACE | | | ne, ferm, | atreat, l | actory, o | ffice | | | | | er or Rural | Route Number, |
| 3 | 4 Nomicide | Could not be determined | building | , atc. (Specif | fy) | | | | | | City or | Town, State |) | | |
| 4 | 29a. CERTIFIER | TIEVING PNYS | SICIAN: To the best of | d my knowle | adon dos | th occur | ad at th | e time d | late and play | a and du | to the cour | e/e) and me | nner en e | Inted | |
| COMPL | one) | and the second | 7.1 500 (0.11) | | | | | | | | | | | | (a) and manner as stated. |
| ္ပ | | 0 | | | | | | ,, | | | 10111-001 | p.ace, e | | | |
| B | 29b. SIGNATURE AND TITL | E OF CERTIFIE | X 1,7 | | | | | | | CENSE NU | 126 | | 29d. D | TE SIGNE | D (Moeth, Day, Year) |
| 2 | 11licu | V V | 94 | 10E 0E 0T | TA 4 | AT (T | D-1 | | | 741 | 70 | | 0 | 10 | 0/7/ |
| - | Alberto Dia | , | | | , | , , , , | | 212 | 04 | | | | | | |
| | 31. DATE FILED (Month, Day | | | | | _ | עניו | -1- | .V-T | | | | | | |
| | SEP 0 8 19 | | Suna Vai | 40000- | Jande | 82 | | | | | | | | | |
| | J 3 - 10 | 4. | U | | · | | | | | | | | | | |

I was a second of the

asp

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| Phy | ysician |
|-----|---------|
| | |
| /N | ledical |
| Ev | aminer |

JOHN MICHAEL SIMMONS Item: 5 per personal Rep. Certificate of Death 1. Decedent's Neme (First, Middle, Last)

Simmons

2. Dete of Deeth 3. Time of Death Month Yeer 1997 AUGUST 10 1954 P

4c. County of Deeth

Funeral Director

28a-f show

7 is marked other than "natural", or items 23s or 28s-f shor traumstic event, the Medical Examiner must be notified as

permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiena. Important if flow 27 is marked other than "natural", or its

Physician /Medical

and

physiclan

attending p

the signed by t

detached

cate has by page 2 s

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, to

the

The law requires that the death certificate be axecuted

P.O. Box 68760.

Records,

Division of Vital

Baltimore, Maryland 21215-0020

the Maryland

8104 15th ave APT#4

4e. Fecility Neme (If not institution, give street end number)

7. Age (In yrs. last birthday) 1⊈M 2□ F Yrs 62

HYATTSVILLE If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Deys

PRINCE **GEORGES** Birthplece (State or Foreign Country)

TITIKTIOWIT Usuei Residence of Decedent

Director

Funeral

by

Completed

Be

Examiner

Physician/Medicai

by

Completed

Be

Medical Certification: To

10e. Stete 10b. County unknown

10c. City, Town or Location unknown

unknown

4b. City, Town, or Location of Deeth

unknown

10e. Street end Number

10f. Zip Code unknown

10d. Inside City Limits UNKNOWN 1 Yes 2 No 10g. Citizen of Whet Country?

unknown

11. Meritel Status unknown 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.
Armed Forces? UNK II CWII
1 | Yes 2 | No
If Yes, Give
Yeer or Detes:

unknown

 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1 ☐ Yes 2 XNo Specify:

14. Race - American Indien, Bleck, White, etc. White Specify:

15. Decedent's Education (Specify only highest grade completed)

17. Father's Name (First, Middle, Last)

College (1-4or 5+)

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/industry

Elementery/Secondery (0-12) unknown

unknown

unknown

unknowr.

unknown

ur.krtown

19a. Informent's Neme/Ratationship (Type, Print)

unknown

unknown

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removei from State 4 □ Donetion 5 ☑Other (Specify) in state

20b. Plece of Disposition (Neme of cemetery, cremetory or other plece)

unknown

20c. Location - City or Town, Stete

21. Signeture of Funeral Service Licensee Ronald S. J

Wade Director I. Enter the disease Mel

22. Name end Address of Fecility

State Anatomy Board, 655 W. Baltimrce Street Baltimore, Maryland 21201

18. Mother's Name (First, Middla, Maiden Sumeme)

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code)

23a. Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, now, or haart failure. List only one cause on each line. Immediate Causa (Final

disease or condition resulting in deeth)

Arteriosclerotic Cardiovascular Disease

Due to (or es a consequance of):

Sequentietly list conditions, if eny, leading to immediate ceuse. Enter Underlying Causa (Disaase or trijury that initieted events resulting in deeth) Lest

Dua to (or as a consequence of)

Due to (or es e consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24e. Wes en eutopsy performed?

INSPECTION

24b. Were autopsy findings aveilebte prior to completion of cause of daeth? 1 TYes 2 No

Approximete Interval Between Onset and Deeth

25. Wes cese referred to medicat 1 X Yes 2 □ No

> 5 Pending investigetion

> 6 Could not be detarmined

1 Inpatiant 2 ER/Outpetlent 3 DOA 28a. Data of Injury (Month, Dey Year) 28b. Time of

28a. Place of Injury - At home, ferm, straet, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 1 Yes 2 No

28d. Dascribe how injury occurred

29a. Certifien

27. Mennar of Death

1. Neturel

2 Accidant 3 Suicide

4 Homicida

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, deta end plece, end due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end manner stated.

29b. Signature and title of certifie

29c. License number O.C.M.E

29d. Dete signed (Month, Dey, Yeer) AUGUST 11, 1997

28f. Location (Street end Number or Rural Route Number, City or Town, Stata)

ddrass of person who completed ceuse of deeth (ttem 23e) (Type, Print)

Hospitei:

in LOCKE

111 Penn Street, Baltimore, Maryland 21201

26. Plece of Death (Check only one)

State Registrar

State of Maryland / Department of Health and Mental Hygiene

3. Tima of Death

3:45 pm

1 ☐ Yes 2 ☐ No

Approximata Interval Between Onset and Death

1 day

years

24b. Wara autopsy tindings available prior to completion of cause of death?

1 ☐ Yas 2 ☐ No

Certificate of Death 1. Decadant's Nama (First, Middla, Last) 2. Data of Daath **Physician** September 5, 1997 Constance Naomi Smith /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Meridian Franklin Woods Rossville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Sacurity Number 8. Data of Birth Allonth, Day, Year, Aug. 21, 1920 9. Birthplace (Stata or Foreign Country) Maryland 7. Aga (In yrs. last birthday) **Funeral** 215 18 4647 Days 1□M 20 F 77 Yrs. Director Usuai Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show a notified at the Maryt Directo Maryland | Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 15 Windward Way 234 21220 USA Funeral 11. Marital Status 12. Was Decadent Ever in U,S. Armed Forcas? Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, atc. 1 ☐ Yas 2 █No If Yes, Give Yaar or Datas: Baltimore, Maryland 21215-0020 1 ☐ Navar Marriad 2 ☐ Married 1 ☐ Yas 2 ☐No Specify: White þ 3 StWidowed 4 ☐ Divorced Completed traumatic event, the Medical 16a. Decedant's Usual Occupation (Give kind of work dona during most of working iffa. DO NOT usa retired) 15. Decedent's Education 16b. Kind of Businass/Industry (Specify only highast grada Hygiene. Elemantary/Secondary (0-12) 12 College (1-4or 5+) Housewife Own Home permit. Pages 1 and 2 abouid be file Department of Health and Mental Hy important: If Item 27 is marked othe any injury or other traumatic avant 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Arthur Benton Malinda Mister 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Dianna Engle (daughter) 15 Windward Way Middle River, Maryland 21220 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, State 1 ☑ Buriai 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) Gardens of Faith Cem. 9/8/1997 Baltimore Co., Maryland 22. Name and Address of Facility
Bruzdzinski Funeral Home PA 1407 Old Eastern Ave Essex, Maryland 21221 or complication. That caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, List only one cardiac on each line. **Physician** /Medical Immediata Causa (Final disease or condition resulting in death) **Examiner** Examiner ancer physician and s the burial-transit Sequentially list conditions, if any, laading to immadiata cause. Enter Undarlying Cause (Diseasa or Injury that Initiated evants rasulting in death) Last Oua to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): attending 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causs of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Musica þ

Division of Vital Records, P.O. Box 68760. signed by t peen page 2 certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; I

Completed

Be

Certification:

Registrar

Medical 29b. Signatura and title of certifier

29a. Certifier

Kolapah. 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

29c. Licanse number

D50757

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

28c. Injury at Work?

1 ☐ Yas 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

24a. Was an autopsy performed?

Othar: 4 12 Nursing Homa 5 Rasidance 6 Othar (Specify)

26. Placa of Death (Check only ona)

1 ☐ Yas 2 No

28d. Dascribe how injury occurred

9200 Franklin Square Drive Rossville, Maryland 21237 Anuradha Ralapati MD

1 Inpatient 2 ER/Outpatient 3 DOA

Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

28b. Time of

31. Data tiled (Month, Day, Year) SEP 0 9 1997

25. Was casa ratarred to medical

5 Panding

invastigation

6 Could not be datamined

1 Tas 2 No

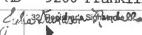
27. Manner of Death 1 DNatural

2 Accidant

3 Suicide

4 Homicida

(Check only one)



28a. Date of Injury (Month, Day Year)

State of Maryland / Department of Health and Mental Hygiene

| hysicia | | 1. Decedent's Nama (First, Middla, Las | st) | | Cer | | | | T | 2. Data of Das | Reg. No. | | 0.70 | n of Da-th |
|--|--------------------------------------|--|--|---|--------------|--|--|---------------------------|----------------------|---|---|--|--|--|
| • | _ | | , | ml | | | | | | Month | Day | Yeer | | a of Death |
| /Medica | _ | Richard Ch. 4a. Fecility Nama (If not institution, give | arles | | ompso | n, J | | City Town | | eptemb ation of Death | | 1997 ty of Death | 4:4 | 9 pm |
| Examine | er | 5907 Foxhall Mano | | | | | 40. | | | | | | | |
| ınerai | - | 5. Social Sacurity Number 6. S | | ga (In yrs. las | t birthday) | If Under 1 | Year i | f Under 24 | | ville B. Date of Birt | Balti | Companies Communication of the | alace (St | te or Foreig |
| rector | | 216 50 3083 | X 2 F | 48 | Yrs. | Months | Days | Hours | Min. | B. Date of Birth (Month, Day une 27 | y, Yaar) 1949 | Mary. | land | ata or Foreig |
| dat | | 10a. State 10b. County | | | Town or Loc | | | | | | | 1 | IOd. Insid | e City Limits |
| Siffed | ctor | Maryland Baltimor | e | | Caton | sville | е | | | | | | 10 | ras 20 No |
| 8 10 | Director | 10e. Street and Number | | | | 10f. Zlp C | oda | | | | 10g. Citizan of | What Cour | ntry? | |
| | ē | 5907 Foxhall Mano | r Drive | | | 21: | 228 | | | | | USA | | |
| | Funeral | 11. Marital Status | 12. Was Decedant Armed Forcas? | Evar in U,S. | 13. V | Vas Dacede Yas, specif | nt of Hispa y Cuban, | anic Origin Maxican, I | n? (Spec Puarto R | ify Yes or No- ican, etc.) | 14. Ra | eck, Whita. | an India | ٦, |
| | þ | 1 Never Marriad 2 Married 3 Widowed 4 Divorced | 1⊠ Yas 2 ☐ If Yas, Giva | No | 1 | ☐ Yes 2 | No 5 | Specify: | | | | ity: Whit | | |
| | etec | 15. Decedant's Ed (Specify only highast gra | lucation de completed) | vieula | 6a. Deced | ant's Usual | Occupatio | on ina most o | f working | , | 16b. Kind of I | Business/Inc | dustry | |
| | Completed | Elementary/Secondary (0-12) | College (1-4or | Vietna 5+) | life. D | O NOT usa | ratired) | | | | | | | |
| 1 | ပိ | 17. Fathar's Name (First, Middla, Last) | 0 | | Soc | iolog: | ISC | | | | US Arm | | ps o | Eng. |
| | 9 Be | Richard C. Thomps | | | | | 10 | | onic | | | ima) | | |
| 1 | 2 | 19a. Informant's Name/Ralationship (7 | • | | 10h Mailine | o Addraes / | Stroot and | | | | r, City or Town | - Ctata Zia | Codel | |
| | | Caroline A. Thomp | | | | | | | | | nsville | | | 28 |
| other traumetic | - | 20e. Mathod of Disposition | (| | | ition (Nama atory or oth | | | | Data | 20c. Location | | | |
| 6 | - 1 | Burlal 2 Cramation 3 4 Donetion 5 Othar (Specify | Ramoval from Stata | | | | | + | 0/0 | | | | | |
| injury # | - | 21. Signatura of Function Service Licent | | St. | | slaus | | | | | Baltim | ore, r | mary. | Land |
| Suc | |) D | ~ | | | | | | | Home P | | | | |
| | 4 | Man Bax | | | 1 1 | 07 01 | 7 Dag | . 4 | | | | 7 7 / | 2122 | 12 |
| | | 00. 5. 4. 5 | | | 14 | 01 010 | ı Eds | stern | Ave | Essex | , Mary | rand a | | |
| | | 23a. Pert1. Entar the disaasa, or comp shock, or haart failura. List only | olications thet causac ona cause on each li | tha deeth. | Do not anta | r the mode | of dylng, s | such es ca | Ave | ESSEX | Mary. | Land a | Approxi Intarval | meta Batween |
| _ | | | | | Do not anta | r the mode | of dying, s | such es ca | rdiec or | raspiratory en | rest, | | Approxi Interval Onset a | meta Batween nd Death |
| al | | 23a. Pert 1. Entar the disaasa, or compensor, or heart failure. List only of Immediate Cause (Final diseasa or condition rasulting in death) | | tastat | Do not anta | GNCV | of dying, s | such es ca | rdiec or | raspiratory en | , Mary. | | Approxi Interval Onset a | meta Batween |
| al er | Jei | Immediate Cause (Final disaasa or condition | | | Do not anta | GNCV | of dying, s | such es ca | rdiec or | raspiratory en | rest, | | Approxi Interval Onset a | meta Batween nd Death |
| al er | miner | Immediate Cause (Final disease or condition rasulting in death) | | tustat Dua to (or as | TO Post anta | GNCV(| of dying, s | such es ca | rdiec or | raspiratory en | rest, | | Approxi Interval Onset a | meta Batween nd Death |
| al er | Examiner | Immediate Cause (Final disease or condition rasulting in death) | | tastat | TO Post anta | GNCV(| of dying, s | such es ca | rdiec or | raspiratory en | rest, | | Approxi Interval Onset a | meta Batween nd Death |
| al er | ical Examiner | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events | a. <u>Me</u> | tustuc Dua to (or a: | Do not anta | GNCV(uence of): | of dying, s | such es ca | rdiec or | raspiratory en | rest, | | Approxi Interval Onset a | meta Batween nd Death |
| r | Medical Examiner | Immediate Cause (Final disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Causa (Disease or injury that initiated events resulting in death) Lest | a. <u>Me</u> | tustat Dua to (or as | Do not anta | GNCV(uence of): | of dying, s | such es ca | rdiec or | raspiratory en | rest, | | Approxi Interval Onset a | meta Batween nd Death |
| cal | ciarymedical Examiner | Immediate Cause (Final disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest | a b c | Dua to (or as | Do not anta | CNCV(uence of): uenca of): | of dying, s | A A | rdiec or | raspiratory en | rest, | | Approxi Interval Onset a | meta Batween nd Death |
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| cal ler ler le le le le le le le le le le le le le | by Physician/Medical | Immediate Cause (Final disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest | a b c | Dua to (or as | Do not anta | CNCV(uence of): uenca of): | of dying, s | A A | rdiec or | O CGVC | inumq | ontribute to | Approxi Interval Onset a 2 W | meta Batween nd Death nonths a of death B Unknow sy findings or to |
| al er | by Physician/Medical | Immediate Cause (Final disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest | a b c | Dua to (or as | Do not anta | CNCV(uence of): uenca of): | of dying, s | A A | rdiec or | 23b. Did to | pbacco use cover 2 No | ontribute to 3 □ Prot | Approxi Interval Onset a Onset | meta Batween nd Death Onth Unknow sy findings or to of cause |
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| Corr., page a sirouto de descricto do des es de Dufa-l'enist. De Complesed by Dhusiofe Blandaria European | be completed by Physician/Medical | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avants resulting in death) Lest Part II. Other significant conditions co | a. Me | Tustur Dua to (or as Dua to (or as ut not rasultir | Do not anta | CNCV(uence of): uenca of): dartying cau | of dying, s | in Part I. | den | 23b. Did to 1 V 24a. Was a perfor | inumq bacco use co se 2 No an autopsy med? | ontribute to 3 □ Prot 24b. We eve con | Approximaterval Onset a Onset | meta Batween nd Death Onth Unknow sy findings or to of cause |
| cal learning to the Commission of the Commission | to be completed by Physician/Medical | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated avents resulting in death) Lest Part II. Other significant conditions condi | a. Me | Tustur Dua to (or as Dua to (or as ut not rasultir | Do not anta | Janca of): uanca of): dartying cau | of dying, so of dy | in Part I. | den | 23b. Did to 1 \(\text{Y} \) 24a. Was a perfor 1 \(\text{Y} \) Check only or | obacco use co 'es 2 No an autopsy med? | ontribute to 3 □ Prot 24b. Wa evi con of to | Approximaterval Onset a Onset | meta Batween nd Death Onth Unknow sy findings or to of cause |
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29c. Licensa number

o completed causa of death (Itam 23a) (Type, Print)

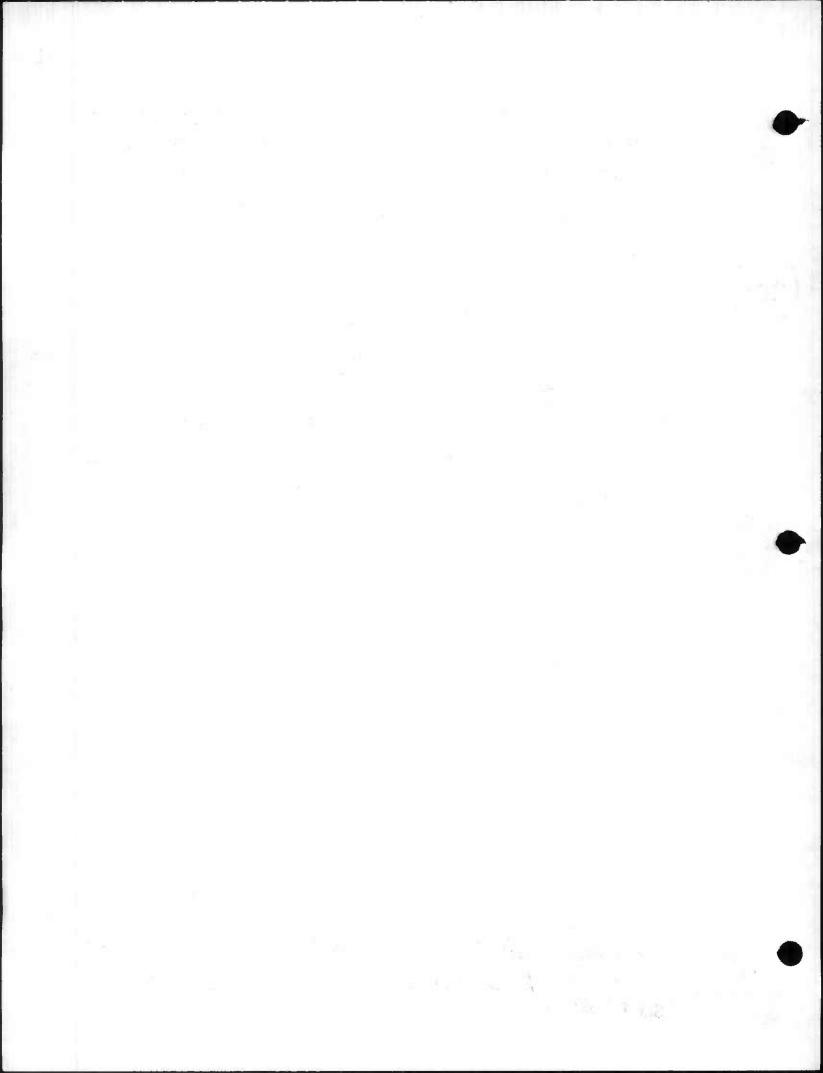
51eh 600 Novib Wolfe 3t. Bultimore MO

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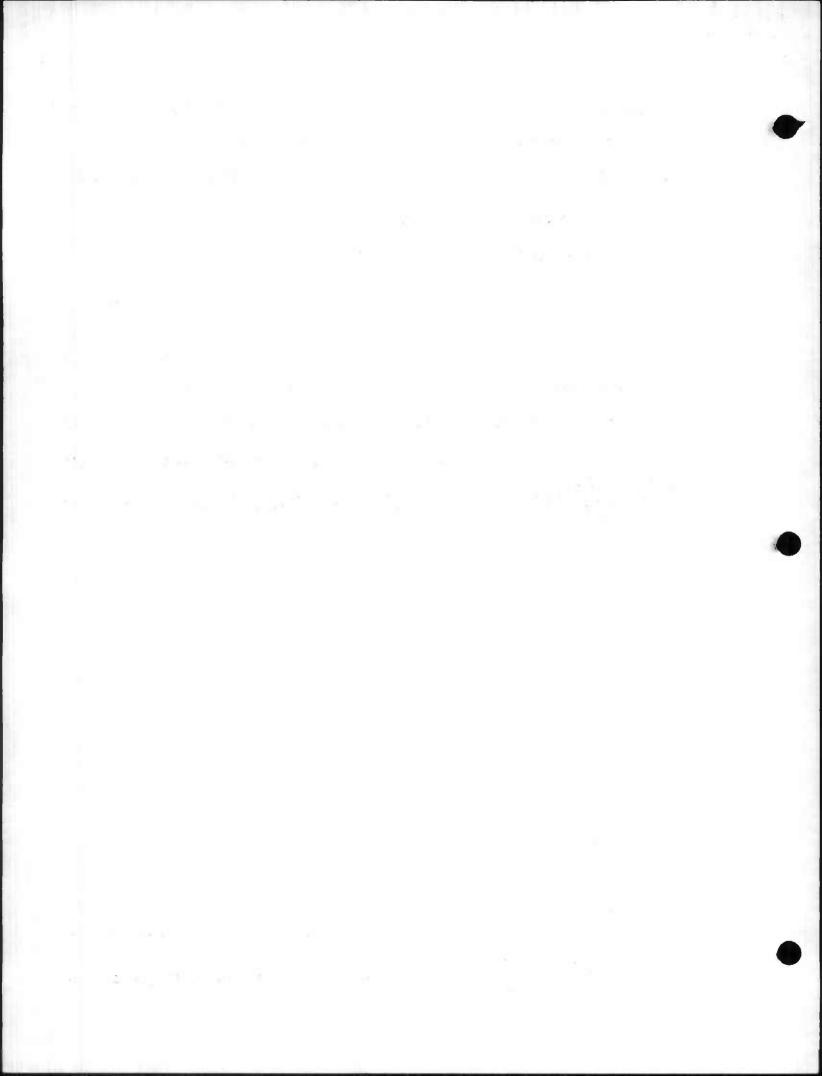
29d. Data signed (Month, Day, Year)

September 6,1997

State Registrar 29b. Signeture end titla of certifiar



| R(ASI | OSE VE | RDU | JCI | Plea | | | | ind / Dep | artmen | t of I | x. Assure A Health and I | | _ | Andrea | 27361 |
|------------|--|------------------|---|--------------------------------------|-------------------------|-----------------------------|---------------------------------|-------------------------------------|----------------------------|-----------------------|--|------------------------------------|---|------------------------------|---|
| | | | art I 27 pe | | | /6/97 | dh | Ce | rtificat | e of | Death | 2. Dete of De | | | 3. Tima of Death |
| ı | Physic /Medi | | Rose | T. Ver | duci | | | | | | | Month SEPTE | MBER 08 | Year 1997 | 12:50 A |
| S | Exami | | 4e. Facility Neme | | | et and num | ber) | | | | 4b. City, Town, or L | | | y of Deeth | 12.50 A |
| 1 | | | NORTH | WEST HO | SPIT | 'AL | | | | | RANDALST | OWN | BALT | IMORE | |
| | Funeral | Г | 5. Social Security | Number | 6. Sex | | 7. Age (In yi | s. lest birthday, | If Under Months | | If Under 24 Hrs. | 8. Dale of Bi (Month, D | | | ece (State or Foreign |
| | Director | | 216-92-9 | | 1 L M | 2 X F | 32 | Yrs. | Months | Days | 110013 1911(). | 08/12/ | 1965 | Maryl | |
| | and *- | | Usual Residenca | of Decedent 10b. County | | | 10c. (| City, Town or Le | ocation | | | | | 10 | d. Inside City Limits |
| | danyi f sho | 0 | Maryland | | imor | 0 | | N/A | | | | | | | 1 ☐ Yas 2\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\ |
| | the h | Director | 10e. Straet and No | | LINOL | _ | | 14/2 | 10f, Zip | Code | | | 10g. Citizen of | What Count | |
| | with with | | | | ~ Do | - 4 | | | · · | | | | | What Count | Ty r |
| | hours after deeth with the Maryland Turat', or items 23s or 28s-f show at Examinet invest be notified at | Funerai | 7019 Gle | ar Sprin | - | | dent Ever in | U.S. 13. | | 244 | | pecify Yes or N | USA 14. Ba | ce - America | ın Indian. |
| 0 | r Her | Fur | | ried 200 Marri | | Armed For 1 ☐ Yes | ces? 2 ∑ No | | | | Hispanic Orlgin? (Sp pan, Mexican, Puerto | Rican, etc.) | Ble | ack, White, e | |
| 020 | urs ail, o | by | | 4 Divorced | | If Yes, Give Year or Da | 9 ** | | 1 ☐ Yes | 2 ∑ No | Specify: | | Speci | by White | е |
| 21215-0020 | 72 hours "natural", | Completed | /Cne | 15. Decedent | 's Educati | ion | | 16a. Dece | dant's Usua | al Occup | pation | lula a | 16b. Kind of I | Business/Ind | ustry |
| 21 | i within 72 ho liene. r than "natur | npie | Elamentary/Sac | ocify only highes condary (0-12) | t grade co | College (1- | 4or 5+) | life. | DO NOT us | se retire | during most of world) | king | | | |
| | filed w Hygier Ither th | S | 12 | | | | | Secre | etary | | | | State | Gover | nment |
| Maryland | should be filed ad Mental Hygi marked other matic event, II | Be | 17. Father's Name | | . , | | | | | | 18. Mother's Nam | | | m <i>ə)</i> | |
| yla | 2 should and Men is marke | P | | cent Pr | | | | | | | | la Spac | | | |
| Mai | 0 6 6 5 | | 19a. Informant's N | | | , | | | | | t and Number or Ru | | | | |
| | Health Health Iem 27 | | Joseph V | | / nu: | spand | 206 | 7019 Placa of Dispo | | | ring Road | | | | |
| 100 | 00- | | | Cremation 5 ☐ Other (Sp | 3 □Ram | oval from S | | camatary, cre | matory or o | ther pla | 1 | Date | 20c. Location | | |
| altimore, | | | | | | | N∈ | w Cathe | | | | /10/97 | Baltimo | ore, M | aryland |
| Ba | Departit Departit Importa any inju | | 21. Signature of F | unoral sprving | n | 11- | | | | | ess of Fecility | wal Hon | 10 | | |
| _ | | | we | rely | "N | ME, |) | 53 | 311 Ec | mon | leber Fune dson Ave. | Baltin | ore. Ma | rylan | đ 21229 |
| я | | | 23a. Part1, Enter shock, or he | the dismiss, or art fallure. List | complicet only one c | ions that ca causa on aa | used the de ich lina. | ath. Do not en | tar the mod | e of dyi | ing, such as cardiec | or respiretory a | rresi, | | Approximate Interval Between |
| | Physician /Medicai | | Immediate Ceuse | (Final | | | | | | | | | | - 1 | Onset end Death |
| | Examiner | | disease or conditi rasulting in death) | on | a. | - Ai | NAPHYLA | XIS AND A | STHMA | | | | | | |
| | | ie i | | | | | Due to | (or as a conse | quance of): | | | | | 1 | |
| | and and -transit | Examiner | | | b | | _ | | | | | | | | |
| o, | | Exa | Sequantielly list of if eny, leading to it | mmadiata | | | Dua to | (or as a consa | quenca of): | | | | | 1 | |
| 260 | | - 1 | causa. Enter Und Cause (Disease o that initiated even | r injury | с. | | Due to | (0. 00 0 00000 | | | | | | + | |
| 9289 | tificet ig phy es th | edi | rasulting in death) | Last | | | Due 10 | (or as a consec | (uenca or): | | | | | 1 | |
| Box | andin use | N/u | | | d. | | | | | | | | | | |
| | death e atte | Physiclan/Medica | Part II. Other algni | ficant condition | ns contrib | uting to dea | ath but not re | suiting in the u | nderlying c | ausa di | ven in Part I | 23b. Did | tobacco usa c | ontribute to | the cause of death? |
| P.0 | that the di ed by the detached | hy | | | | | | 3 | , , , | | | | Yes 2□ No | 3 □ Prob | |
| | es the | by F | - | | | | | | | | | | | | |
| Records, | The law requires that the ate has been signed by the page 2 should be detache | | | | | | | | | | | 24a. Was | an autopsy | 24b. Wei | re autopsy findings ilable prior to |
| 000 | hes be | Completed | | | | | | | | | | Pon | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | corr | plellon of cause leath? |
| | The la | mo: | | | | | | | | | | 15ব | Yes 2□No | 162 | Yes 2□ No |
| Vital | | Be | 25. Was case refa | rrad to medical | | | | | | | 26. Place of Dea | th (Check only | one) | | |
| of V | 0 0 | To | examiner? |] No | Hosp | oital: 1 □ In | patient 2 | ☐ ER/Oulpetie | n 3⊡ x DO | Oth | her: 4 Nursing He | ome 5 Res | denca 6 □Ot | her (Specify) |) |
| | ding Ph h. After th funeral | | 27. Mannar of Dea | th 5 Pending | | 28a. Date of | Injury , Day Year) | 28b. Time o | 1 2 | 8c. Inju | ry at | 28d. Describe | how injury occu | rred | |
| Division | | Certification: | 2 Accidant | Investig | ation | (| ,,, | | M | | Yes 2□No | | | | |
| i Vis | or Attendent of the Director: | tific | 3 ☐ Suicide 4 ☐ Homlcide | 6 Could n determi | | 28a. Placa o buildin | of Injury - At g, etc. (Spec | home, farm, st | eet, factory | , offica | | 28f. Location (City or To | Street and Num wn, State) | ber or Aural | Route Number, |
| | its of it | | | _ | | | | | | | | | | | |
| | To the Hospital within 24 hours of To the Funeral Completely filled | edlcai | 29a. Cartifier (Check only one) | 1☐ Certifying 2☐ Medicai E | Physicia xaminar: | On the bas and manne | sis of axamir | nowladga, daati nation and/or in | occurred a vestigation, | at tha tii in my c | me, data and placa, opinion, daath occur | and due to the red at tha tima, | cause(s) and m data and place | anner as sta , and due to | ited. the cause(s) |
| | To the within 2 To the comple | Σ | 29b. Signature end | d litle of certifier | 0 | , | | | | | se number | | 29d. Dete sign | | |
| | | | An | m= (| 1/2 | it to | 40 | | 0 | .C.N | 1.E | | SEPTEMB | ER 08, | 1997 |
| | | | 30. Nama and add | ress of person v | nho comp | ieted causa | of death (Ite | em 23a) (Type, | | | | | | | |
| | | | Dennis | | vte, | MO | | 1 | 11 Per | nn S | Street, B | altimor | e, Mary | land 2 | 1201 |
| | Sta | te | 31. Data filed (Mor | oth, Day, Year) | , | 32. Be | giswa's Sig | nature m—/andel | | | | - | | | |
| | Registr | ar | OLL | 0 0 1331 | | 0 | - KNAVIAN | a-Nover | Ma | | | | | | |



State of Maryland / Department of Health and Mental Hygiene 97 27362

| | ********** | | | | | | Cer | tificate c | of Death | 1 | Reg. No. | | | | |
|------------|---|---------------------|--|--|--|----------------------------|------------------------|--------------------------------|---|---|--------------------------------|-------------------------------------|--|--|--|
| | Ohyoia | ian | 1. Dacedent's Name (Firs | | 7 | | | | | 2. Date of Dea | | Year | 3. Time of Daath | | |
| | Physic Medi/ | | Alice M | arie | Willia | ms | | | | | BER 4, | | 10:55AM | | |
| | Exami | | 4a. Facility Name (If not in | stitution, giv | e street and number |) | | | 4b. City, Town, or | Location of Death | 4c. County | of Death | | | |
| | 3,8 | | 1401 LAKEW | | | | | | BALTIMO | | NA | | | | |
| 1 | Funerai Director | | 5. Social Security Number 217-07-05 | 44 1 | ex 7. A □ M 2 F | ge (In yrs. 72 | last birthday) Yrs. | If Under 1 Ya Months Day | | | v, Year) | 9. Birthp Coun | lace (State or Foreign Md • | | |
| П | pus * | 1 | Usual Residence of Deced 10a, State 10b. | dent County | | 10c City | y, Town or Loc | eation | | | | 1 | Od In oldo City Limite | | |
| | ath with the Marylar 23s or 28s-f show | ctor | Md. NA | | | Ва | ltimo | | | | | | 0d. Inside City Limits 1 Yes 2 No | | |
| | or 20 | Dire | 10e. Street and Number | | | Apt. | #105 | 10f. Zip Code | | | 10g. Citizen of N | What Coun | itry? | | |
| | ath w | ral | 1401 Nor | En L | | | | 212 | | | USA | | | | |
| 020 | 72 hours after death with the Maryland natural, or items 23a or 28a-f show first Enaminer must be notified at | by Funeral Director | 11. Marital Status 1 Never Married 2 3 XWidowed 4 D | | 12. Was Decedent Armad Forces 1 ☐ Yes ♣ If Yes, Give Year or Datas: | ? No | | Vas Decedent of Yas, specify C | of Hispanic Origin? (Suban, Mexican, Puer No Specify: | Specify Yas or No- to Rican, etc.) | | ce - Americ ck, White, V: Bla | etc. | | |
| 2-0 | "natural", | De le | 15. D | ecedent's Ed | lucation | | 16a. Deced | ent's Usual Occ | cupation | dian | 16b. Kind of Business/Industry | | | | |
| 21215-0020 | d within giene. r than " | Completed | Elementary/Secondary 8th Grade | 0-12) | de completed) College (1-4or | 5+) | Dome | | ne during most of wo ired) | rking | other | peo | ple home | | |
| Maryland | d ta b | To Be C | 17. Father's Name (First,) Charlie | Aiddle, Last) | | and | | | | other's Name (First, Middle, Maiden Surname) Lovelean Watts | | | | | |
| ary | 2 should be and Mentals marked | - | 19a. Informant's Name/Re | | | | 19b. Maitin | g Address (Stre | Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | |
| | 1 and 2 Heeith em 27 i | | Pricillia | Wil | liam-Abn | iam-Abney 5303 Pembroke Av | | | | | enue Baltimore, Maryland | | | | |
| altimore, | Page nent o int: If i | | 20a. Method of Disposition 1 X Burial 2 ☐ Cren | | Ramoval from State | CI | emetery, crem | atory or other p | Date 20c. Location - City or Town, State 29-10-97 Randallstown. | | | | | | |
| tim | | | 4 □ Donation 5 □ O | | | Ki | ng Me | m. Pk. | Cem. O | 9-10-97 | Rand | lalls | town. Mo | | |
| Bal | permit. Departrimporta any inju | | 21. Signature of Funeral S | ervice Licen | ies . | | | | | | | _ | and 21202 | | |
| п | 100 | | 23a. Part1. Enter the dise | ase, or comp | WM.C.March FH 1101 E. North Avenue Discations that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, one cause on each tine. Approximately a such as cardiac or raspiratory arrest, one cause on each tine. | | | | | | | | | | |
| ı | Physician | | SHOOK, OF HOUSE FAIROR | o. List Offiny | one cause on each | urie. | | | | | | 1 | Intervat Between Onset and Death | | |
| | /Medical Examiner | | Immediate Cause (Final disease or condition | | Arterio | scle | otic (| ardiova | ascular Di | sease | | - 1 | | | |
| п | LAGITITICI | نيوا | resulting in death) | | u. | | r as a consequ | | | | | | - (1) | | |
| Ξ | bed 1sit | nine | | | b | | | | | | | 1 | | | |
| | certificate be executed rding physician end use es the buriel-transit | Examiner | Sequentially list conditions if any, leading to immedia cause. Enter Underlying Cause (Disease or Injury | | | | | | | | | | | | |
| 68760, | slciar buri | | Cause (Disease or Injury that initiated events | ~ | C | Dura to /or | | | | | | | | | |
| 68 | ificati g phy es the | Medical | rasulting in daath) Last | - 1 | | Due to (or | as a consequ | ience ot): | | | | | | | |
| XO | leath certifica attending ph d for use es t | | | | d | | | | | | | | | | |
| B. | 0 0 4 | sician | Part II. Other significant c | onditiona co | ontributing to death t | out not resu | ilting in the un | derlying cause | given in Part I. | 23b. Did t | obacco use co | ntributa to | the cause of death | | |
| , P.O | ed by detac | by Phy | | | | | | , | | | | | bably XXUnknow | | |
| ecords, | requir been s | Completed b | | | | | | | | 24a. Was perfor | an autopsy med? | ava cor | ere autopsy findings altable prior fo impletion of cause | | |
| Re | The law ate has b page 2 s | ршс | | | | | | | | INSPE | | | death? | | |
| Vital | | | 25. Was case referred to r | nedicat | | | | | OC Phase of De | 1 | Λ | 11 | Yes XXNo | | |
| | Physician: this certific ral director, | o Be | examiner? XXYes 2□ No | | Hospital: | ient 2 🗆 | ER/Outpatient | 3□ DOA | Other: | ath <i>(Check only o</i> flome 5 ☑ Resid | | ne (Canaih | u) | | |
| of | 五 年 章 | n: T | 27. Manner of Death | | 28a. Date of this | ury | 28b. Time of | 28c. In | | 28d. Describe h | | | 9 | | |
| Division | Attending or death. ector: After by the fune | Certification: | 2 Accident | Pending investigation Could not be | | | Injury | M 1 | ☐ Yes 2☐ No | 201 1 1 15 | | | | | |
| Div | a of Attendent's effer deat | Certif | 4 ☐ Homlcide | determined | 28e. Place of In building, e | tc. (Specify | me, tarm, stre | et, factory, offic | ×9 | City or Tow | | oer or Hura | I Route Number, | | |
| | To the Hospital or within 24 hours effe To the Funeral Dir completely filled in | edical | | | | f examinati | | | time, date and place y opinion, death occu | | | | | | |
| | To the Within To the | X | 29b. Signatura and title of | certifier | 11 K. | | 1 | 29c. Lice | ensa number | | 29d. Data signe | d (Month, | Day, Year) | | |
| | | | D. Denni | S J. C | U. King , | no / | top- | (| O.C.M.E. | | SEPTEME | BER 4 | , 1997 | | |
| | 7) | | 30. Name and address of p | erson who | completed cause of | death (Item | 23a) (Type, F | Print) | 2-14-2 | Mar- 7: | | | | | |

State Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Q 7 27363

| | | | | | | ertificate of | Death | | eg. No. | 1 4 | 1303 |
|------------|---|----------------|---|--|--|---|--|---|------------------------------------|---------------------------|---|
| ı | Physic | ian | Decedant's Nama (First, Mi BEATRICE | iddla, Last) | 7 | IGGLES | | 2. Data of Dear | - | 997 | 3. Tima of Death 7:35 PM |
| | /Medi Examii | | 4a. Facility Nama (If not Institu | ition, giva straat and number | | | 4b. City, Town, or Lo | SEPT. | 4c. County | | 7:33 PM |
| | | 101 | | PAFF RD., APT | | | BALTIMOR | E | N/ | | |
| | Funeral Director | | 5. Social Sacurity Number 577–48–7602 | 1□ M 2□XF | ga (In yrs. last birthda 97 Yrs. | y) if Undar 1 Yaar Months Days | | 8. Data of Birth (Month, Day DEC - 24 | ,1899 | | lace (Stata or Foreign try) RUSSIA |
| | Maryland f show | | Usual Rasidanca of Dacedant 10a. Stata 10b. Cou | | 10c. City, Town or | Location | | | | 10 | Od. Insida City Limits |
| | Maryla -1 sho otified at | ctor | MD N | I/A | BA | LTIMORE | | | | | 1 XYas 2 No |
| (| 114 | rai Director | 10e. Street and Numbar 2909 FALLST | CAFF RD., APT | . 47 | 10f. Zip Coda 212 | 209 | 1 | 0g. Citizan of V US | | try? |
| 020 | hour afer one lural. | by Puneral | 11. Marital Status 1 □ Navar Marriad 2 □ N 3 □ XXXIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII | M Van ChinA | No | 3. Was Decedant of H If Yas, specify Cub 1 ☐ Yas 2 ☐ No | dispanic Origin? (Spe an, Maxican, Puarto I Specify: | cify Yas or No- Rican, atc.) | Biac | e - Amaric k, Whita, i | atc. |
| 21215-002 | "na" | Completed | 15. Decec (Specify only hig Elemantary/Secondary (0-12 | dant's Education shast grada complated) 2) College (1-4or | (Gi | | pation during most of workind) | ng | 16b. Kind of Bu | | |
| | filed with Hygiene. other then | Co | 10 17. Fathar's Name (First, Midd | fla. Last) | P | ROPRIETOR | 18. Mothar's Nema | | | | CTRIC CO. |
| Maryland | should be filed of Mental Hygi marked other matic event, I | To Be | HARRY | nu, Lasty | RICHM | ΔN | NAC | | | IKNOWI | NT. |
| Many | 2 4 6 | | 19a. Informant's Name/Ralatio | | 19b. Me | iling Addrass (Street | and Number or Rure | l Routa Number | City or Town, | | |
| | 1 end Health em 27 ther tr | | MRS. NAOMI 20a. Mathod of Disposition | LEVIN (DAUG. | | 5 ENGLEMEA position (Name of | ADE RD. | | O., MD | | 208 |
| Baltimore, | 0 0 | | | on 3 Ramoval from State | camatary, c | ramatory or othar pla | | | 20c. Location - | | |
| altii | permit. Peg Department Important: It any Injury o | | 21. Signature of Funaral Sarvi | | BETH | TFILOH 22. Nama and Addra | ass of Facility | | BALTIMO | RE, I | 'ID |
| Ω | 88 2 5 8 | | | Jays tel | l | | NSON & BRO STERSTOWN | | | .E. MI | 21208 |
| | Physician | | 23a. Part1. Entar tha disaas shock, or haart feilura | or complications that causa int only ona ceusa on each | | intar tha moda of dyli | ng, such as cardiac o | r raspiratory arr | ast, | | Approximata Intarval Between Onset and Death |
| 1 | /Medical Examiner | | Immediata Cause (Finalidisaasa or condition rasulting in daeth) | 0. | | : Tash | n ² P | | | | pringl |
| Ц | п « | ner | | C | Pua to (or as a cons | equenca of): | Lar Acc | idahl | | | m ca |
| | ificata be axecuted g physician and as the bunal-transit | Examiner | Sequentially list conditions, | C 6. | Dua to (or as a cons | | | | | | 1. |
| 68760, | s be a | | Sequantially list conditions, if any, leeding to immediate causa. Entar Undarlying Causa (Disaasa or Injury thet Initieted avents | c | 11/2 be to | 7 | | | | 2 | LANG |
| Box 68 | ₩ O 0 | n/Medicai | rasulting In death) Last | d | Qua to (or as a cons | Breb)} | | | | 8 | W |
| | na death the atte | Physician/N | Pert II. Other aignificant cond | itions contributing to deeth I | out not rasulting in the | undarlying causa giv | ven in Part I. | 23b. Did to | bacco usa cor | ntributa to | the cause of death? |
| P.0 | that the de ad by the detached | | | | | | | 1 🗆 Y | es 2 No | 3 Prot | pabiy 4 🗆 Unknown |
| Records, | The law requires that the death cer ste has been signed by the attendir page 2 should be detached for use | Completed by | | | | | | 24a. Was a perform | | cor | tra autopsy findings allabla prior to mplation of causa death? |
| I Re | The law ste has page 2 | Som | | | | | | 1 □ Ye | s 2 No | | Yas 2 No |
| Vital | iclan: The l certificate hi rector, page | Be | 25. Was casa rafarred to medi axaminer? | | | l au | 26. Placa of Death | (Check only on | 10) | <u> </u> | |
| of | Phys this al di | : To | 1 ☐ Yes 2 No 27. Mennar of Deeth | Hospital: | | BIII 3L DOA | nar: 4 ☐ Nursing Hon | ne 5 Reside | | |) |
| ion | tending Ph leath. tor: Attar th the funeral | ation | 1 Naturel 5 ☐ Pan | ding (Month, Destigation | iy Year) Injury | Wor | rk? Yas 2□No | .00. 00001100 110 | w injury occurr | 00 | |
| Division | al or Attending Is after death. I Director: After | Certification: | 3 Suicida 6 Cou 4 Homicide data | imined 286. Placa of In | jury - At homa, farm, ic. (Specify) | street, factory, office | 2 | 28f. Location (St City or Town | raat and Numb n, Stata) | er or Rura | l Route Number, |
| | To the Hospital or A within 24 hours after To the Funeral Direct Completely filled in b | edicai (| 29e. Cartifier 1 ☐ Certific (Check only one) 1 ☐ Certific 2 ☐ Madic | ying Physician: To the best al Examinar: On the basis of and menner st | f axamination and/or | ath occurred at the tir Invastigation, in my o | me, date and placa, a opinion, daath occurre | and dua to tha ca ad at tha tima, d | ause(s) end me ata and place, a | nner es st and dua to | eted. tha cause(s) |
| | To the Com | Σ | 29b. Signators and titla of carti | ifiar P | | 29c. Licans | sa number | 2 | 9d. Data signed | d (Month, I | Day, Year) |
| | \sim | | 1/00 | rux down | - N' D | 0 | 6143 | | 9/4/ | 97 | |
| | 13 | | 30. Nama and address of person | AH LEI | TIN M. | 0 | 21 En | fant f | 1. 21 | 201 | Md |
| | Sta Registr | | SEP 0 9 19 | / / / | rar's Signatura Vauidson-Rand | 282 | | | | | |

State of Maryland / Department of Health and Mental Hygiene 97 27361.

| | | | | | , mary la | | tificate of | Death | | leg. No. | 1 | 21304 |
|---------------------|--|------------------|---|---|--|----------------------------------|---|---|--|----------------------------------|-------------------------|--|
| | Physic | | Decedent's Nema (First, Mide John | de, Last) Quinc | 237 | | ADAM | (C | 2. Dete of Dee Month | Day | Yaar | 3. Time of Death |
| d | /Medi Exami | | 4e. Facility Neme (If not instituti | | - | | | 4b. City, Town, or L | Septemb ocation of Deeth | 4c. County | | 3:52 A.M. |
| 1 | Exami | iei | Franklin Squar | | | r | | Rosedale | | Balti | | |
| | Funeral Director | | 5. Sociel Sacurity Number 220-05-0674 | 6. Sex 1 X M 2 □ F | 7. Age (In yrs. 76 | | If Undar 1 Yaar Months Deys | | 8. Dete of Birth (Month, Dey Dec. 31 | | | place (Stete or Foreign offy) Yland |
| | pu » | | Usuei Residence of Decedent 10e. Stete 10b. Count | | 10c Ci | ty, Town or Lo | ontion | | | | | 104 1-14-04-11-4- |
| | sho | 5 | | timore | 100.01 | ty, Town of Lo | Baltin | 1010 | | | | 1 ☐ Yes 2 No |
| | the N | ect | Maryland Bala 10e. Street end Number | unore | | | 10f. Zip Coda | none | | 0g. Citizen of V | Affin and Consul | |
| | 23a or | Funeral Director | 4714 Vicky Ro | pad | | | Tot. Zip Coda | 21236 | | | S.A. | ntry ? |
| 020 | s 1 and 2 should be filed within 72 hours efter death with the Maryland Health and Mental hygiene. Item 27 is marked other than "naturel", or items 23s or 28s-f show other traumstic event, the Medical Examiner must be notified at | þ | 11. Maritel Status 1 □ Nevar Merriad 2 ☑ Ma 3 □ Widowed 4 □ Divorce | mied 1 X Yas | ve |) | Ves Decedent of I f Yes, specify Cub I ☐ Yes 2 🛣 No | dispanto Ortgin? (Spen, Mexican, Puarto Specify: | pecify Yes or No- Rican, atc.) | | e - Amarick, White, | |
| 2-0 | 72 ho | ted | | nt's Education | | 16e. Deced | lent's Usuel Occup | pation | cina | 16b. Kind of B | usiness/in | dustry |
| 21 | thin 7 | Completed | Elemantary/Secondery (0-12) | est grede complated) Coilege (| 1-4or 5+) | | | during most of work d) | | | | |
| 21 | ed wi | Sol | | 4 | · | E | igineer | | | u.s. Go | vern | ment |
| Maryland 21215-0020 | 2 should be filed withing and Mental Hygiene. s marked other than aumatic event, the M | To Be | 17. Fether's Nema (First, Middle Henry | Adams | | | | 18. Mother's Nam Mary | | Meiden Surnem ith | ne) | |
| | and 2 sho saith and I n 27 is me er traume | | 19e. Informent's Name/Reletion Ruth N. Adams | | | | - | and Number or Aus Road, Bal | | | | Coda) |
| re, | other tr | | 20e. Method of Disposition | | 20b. F | Pleca of Dispo | sition (Nama of netory or other pla | ne) | Data | 20c. Location - | City or To | own, Stete |
| E | Peges nent of I nt: If Its iry or o | | 1 Buriei 2 Cremetion 4 Donetion 5 Other (| | | | urk Cemet | tery ! | 9/11/97 | Baltimo | re, | Maryland |
| Baltimore, | permit. Peges 1 and Department of Health Important: If Itam 27 any Injury or other tr once. | | 21. Signature of Funarai Service | Licensee | / | - | Name and Addre | ess of Fecility E Funeral | Homes. | Inc. | | |
| | Physician | | 23a. Pert1. Enter the diseasa, c shock, or heert failure. Lis | or complications that c it only one cause on e | caused the deef each line. | | | right, Rd., 1 ng, such es cardiec | | | 2123 | Approximate Intervei Between Onset and Deeth |
| | /Medical Examiner | L | Immedieta Ceusa (Finei disaase or condition resulting In deeth) | e. AC | Due to (| MYO CO | ARDIAL uence of): | INFAR | CTIN | | | 30 minute |
| - | be sit | ine | | Cos | ZINAM | 4 05 | stry ! | DISTASE | | | | 10 YEARS |
| , | execut n end al-tran | Examiner | Sequentielly list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Disaasa or injury that initiated events | | Due to (d | or as a conseq | uenca of): | | | | 1 | |
| Box 68760, | eath certificate be executed ettending physician end for use es the burial-transit | ledicai | Couse (Disassa or injury that initiated events resulting in deeth) Last | c | Due to (c | or es e conseq | uance of): | | | | | |
| | death d for | Icia | Pert il. Other eignificant condit | ione contributing to de | eath but not res | ulting in the ur | darlying cause ob | ven in Pert I | 23h Did to | phaceo use co | atribute t | o the cause of death? |
| , P.O | es that the digned by the be deteched | by Physician/N | DIABLIES | | | | | | 1□ Y | 1 | 3 □ Pro | |
| of Vital Records, | aw requir is been s 2 should | Completed t | HYPERTEMSI | in; con | 225714 | E HE | ng fa | ILUNE | 24e. Wes e perform | | av | are eutopsy findings alleble prior to impletion of cause deeth? |
| <u> </u> | The it | No. | | | | | | | 1 🗆 Y | es No | 1 | □Yas 2□ No |
| ita | Ician: The sertificate rector, pay | Be (| 25. Was case referred to madic examiner? | | | | | 26. Placa of Deel | th (Check only or | ne) | | |
| E, | | 70 | 1□ Yas 2MNo | Hospitai: 1 🗆 I | npatient 2 | ER/Outpatien | t 3 DOA Oth | nar: 4 Nursing Ho | oma 5 🗆 Raside | ence 6 Oth | ar (Speci | ý) |
| | Right | ation: | 27. Manner of Deeth 1. Netural 5 Pend 2 Accident invest | ng (Monti | of Injury th, Dey Year) | 28b. Time of injury | 28c. Injur Wor M 1 □ | y et rk? Yes 2 □ No | 28d. Dascribe ho | ow injury occur | red | |
| Division | after des Birector d in by th | Certification: | 3 ☐ Sulcida 6 ☐ Couic 4 ☐ Hornicide deten | nined 286. Pieca | of Injury - At hing, etc. (Specif | ome, ferm, stra | aet, factory, office | | 28f. Location (Si City or Town | treet end Numb n, Stete) | per or Run | al Route Number, |
| | To the Hospital or Ag within 24 hours after o To the Funeral Direct completely filled in by | edicai C | 29a. Certifier Check only one) Certifyl | ng Physician: To the Examiner: On the be and mane | best of my kno asis of axamina nar steted. | wiedga, daath tion and/or inv | occurred at the tirestigetion, in my o | me, date end plece, opinion, daath occur | end due to the c red at tha tima, d | euse(s) end me ata and placa, | enner es s and dua t | teted. the cause(s) |
| | within 2 To the comple | Me | 29b. Signature end title of certifi | er | | | 29c. Licens | se number | 2 | 9d. Dete signe | d (Month, | Dey, Year) |
| | ^ | | 1 mm | -Men | -6 | | 018 | 642 | | 9/8/ | 57 | |
| | 19 | | 30. Nama end addrass of person | who complated caus | a of deeth (Iter | n 23e) (Type, | Print) | 00 | Can | | | A Particular de la Companya de la Co |
| | | | - LALTURALL | J. W. J. | 17.18.1 | 5 1/07/1 | . A. Ky. | BALT, | y. 7 | レルろう | 1 | |

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item 8 Per FH Film G751 9-10-97 Certificate of Death rja 1. Decedant's Name (First, Middle Last) 2. Data of Death 3 Time of Death Month **Physician** ildre :35A.M /Medical (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1Salt lamavitin NA +05hit5 29 If Undar 24 Hrs. 5. Social Sacurity Numbar 6. Sax 7. Aga (In yrs. last birthday) if Under 1 Yaar 8. Data of Birth Birthpieca (Stata or Foraign Country) **Funeral** Year) 1 M 2 XF Months Days Hours 8-20-874 Director -eb Usual Rasidance of Dacadani death with the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Baltimore Yas 2 No Director Md 10e Streat and Number 10f. Zip Coda 10g. Citizen of What Country? 6 or items 23a 21217 Funeral 5 /errace Was Dacedant Evar in U.S. Was Dacadant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxicen, Puerto Rican, atc.) Race - Amaricen Indian Black, Whita, atc. 11. Marital Status Armed Forces?

1 Yas 2 No
If Yes, Giva filed within 72 hours after 1 Navar Marriad 2 Marriad Baltimore, Maryland 21215-0020 1 Yas 2 No Specify Specify: Black à 3 Widowad 4 Divorced Yaar or Datas natural Completed 15. Dacedant's Education (Spacify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry than " Naval Elamantary/Secondary (0-12) Collega (1-4or 5+) Base Hygiene. permit. Peges 1 and 2 should be filed with Department of Health and Mental Hygien Important: If tern 27 is marked other that any Injury or other transment. Nurse 12 h grade 2413 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Neme (First, Middla, Maiden Sumema) Be John Chem 2 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Straet and Number or Rural Route Number, City or Town, Steta, Zip Coda) Northbour 43 Whitener Daughter Hlverta Dalto, Md 20a. Mathod of Disposition

Surlai 2 Cramation 3 Ramoval from Stata 20b. Place of Disposition (Nema of cometary, cramatory or other 20c. Location - City or Town, Stata Data 4 ☐ Donetion 5 ☐ Othar (Spacify) da 115 town, 14 21. Signatury of Fundrai Sarvice Licensaa 22. Nama and Addrass of Facility 140 MG uabash Fintar tha disaasa, or complications that ceusad tha daath. Do not antar tha mode of dying, such as cerdiac or respiratory arrast, or haart feilure. List only one ceusa on each line. Approximata Intarvel Batwean Onsat and Death **Physician** immadiata Ceusa (Finel disaasa or condition rasulting in death) /Medical ZhE O Carro Examiner Examiner CULUMAN OIV as that the death certificate be executed pue bunel-tran Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Ceusa (Disaasa or Injury Dua to (or as a consequence of): P.O. Box 68760. ettending physician for use es the burie Physician/Medical that initiated avants rasulting in daath) Last the Dua to (or as a consequance of): igned by the e Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 N Unknown 1 Yes 2 No Division of Vital Records, þ Completed 24b. Were autopsy findings available prior to completion of ceusa of daath? 24a. Was an autopsy performed? 2 No 1 ☐ Yas 2 ☐ No Be 25. Was cesa rafarrad to medicel axaminar? 26. Placa of Deeth (Check only ona) or Attending Physician Othar: 4 Nursing Homa 5 Rasidance 8 Other (Specify) P 1 Yas 2 No 2 ER/Outpatient 3□ DOA 1 Inpatiant this Deta of Injury (Month, Day Year) 27. Manner of Death 28c. injury at Work? 28b. Tima of 28d. Dascribe how injury occurred After 1 Natural 5 Panding invastigation death. 1 Yas 2 No To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fi 2 Accident 6 Could not ba 28f. Location (Straat and Number or Rural Routa Number, City or Town, Steta) 3 Sulcida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida 29e. Cartifiar 1 Cartifying Physician: To the best of my knowledge, daath occurred at tha time, date end placa, and dua to the causa(s) and manner es steled.

2 Madical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date and place, and due to the causa(s) and mennar stated. Medical (Check only one) 29b. Signatura and titia of certifier 29c. Licansa numbar 29d. Data signed (Month, Day, Yaar) IC 30. Neme and address of person who completed cause of daath (Item 23a) (Type, Print) Mo DUS (Ullins

10

32. Registrar's Signeture

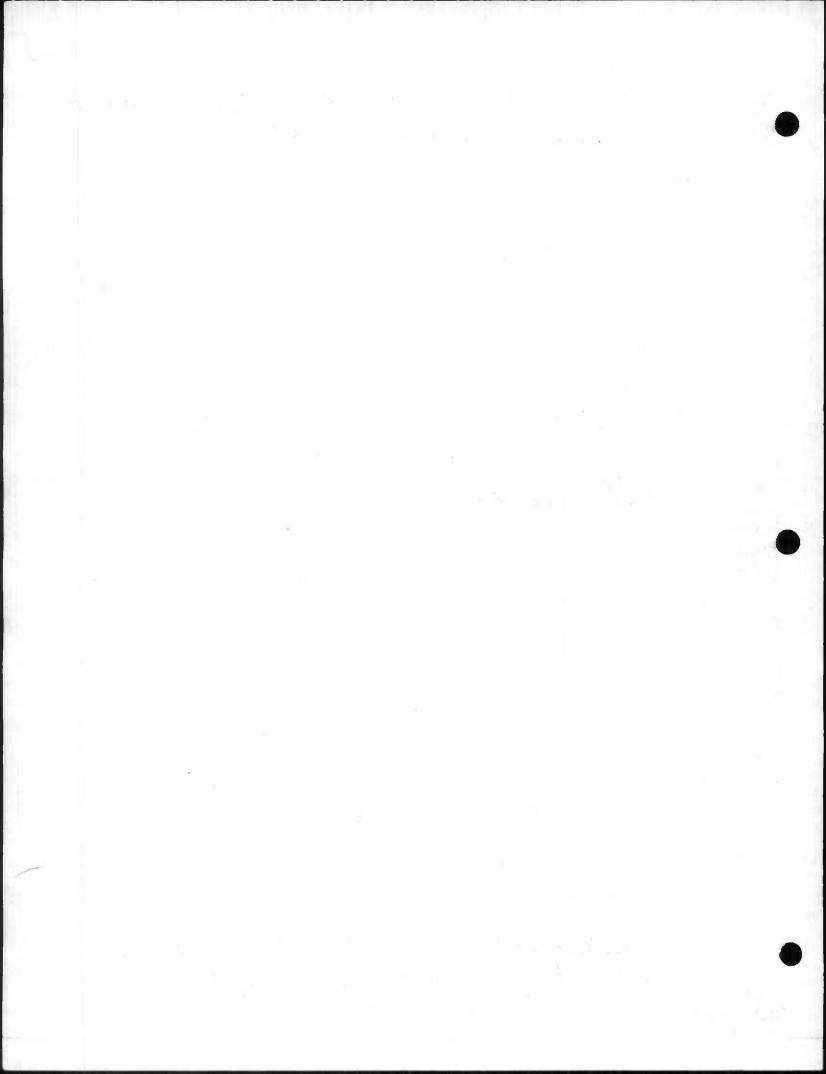
wha Davidson-Randelle

State Registrar

31. Date filed (Month, Day, Yaer)

P

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WRC 97-5102-003 WILLIAM A. ARMENTROUT

Physician

/Medical

Examiner

Directo

Funerai

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Completed

Funeral

Director

7 is marked other than "natural", or items 23s or 28a-f show traumetic event, the Medical Examiner main be multified at

should be filed within 7, and Mental Hygiane, marked other than "na

12 should be fill h and Mental H is marked out

mit. Pages 1 and 2 partment of Health a portant: If Item 27 is y injury or other tra

permit. Page Department of Important: If any injury or

Physician

/Medical Examiner

> buriel-transit and

physician s the buriel

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24 hours a Funeral C

To the within 2 To the

Box 68760

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Division

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Physician/Medical

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Certification:

Pages nent of h

the Maryland

Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of

| f Health and Mental H | ygiene | 9 | 7 | 2 | 7 | 3 | 6 | 6 |
|-----------------------|--------|---|---|---|---|---|---|---|
| of Death | Reg No | | | - | 8 | | 0 | - |

Certificate of 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPT. 07, 1997 ear William Alan Armentrout 3:37 AM. 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death NORTH ARUNDEL HOSPITAL GLEN BURNIE Anne Arundel 5. Social Security Number If Under 1 Year if Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days 1 XM 2 ☐ F 216-92-3971 Yrs 31 March 12,1966 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Pasadena Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 8444 Lockwood Road U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Yeer or Dates: White 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 XDivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry McDevitt and Son

College (1-4or 5+) Elementary/Secondary (0-12) 12 N/A 17. Father's Name (First, Middle, Last)

Plumbing and Heating General Contractor 18. Mother's Name (First, Middle, Maiden Sumame)

Edward R. Armentrout Luree E. Emanuel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8444 Lockwood Road Pasadena, Maryland 21122 Edward R. Armentrout Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

21. Signeture of Fuseral/Service License 2120

Glen Haven Mem. Park Sept. 11, 1997 Glen Burnie, Maryland 22. Name and Address of Fecility

McCully-Polyniak Funeral Home 3204 Mountain Road Pasadena, Maryland 21122 rt1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting In death)

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last

Due to (or as a consequence of)

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy

24b. Were autopsy findings available prior to completion of ceuse of deeth?

1 Yes 2 □ No

Yes 2 No

25. Was cese referred to medical examiner?

**XXYes 2□ No

27. Manner of Death

1 Natural

29a. Certifier

Hospital: 1 ☐ Inpatient 2 💢 ER/Outpatient 3 ☐ DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year)

28c. Injury at Work?

1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred motor vehicle collition

5 Pending investigation 00 30 A M 9-7-97 2 Accident Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

281. Location (Street and Number or Rural Route Number, City or Town, State) Mountain Road

(Check only one) 29b. Signature and title of certifier

29c. License number O.C.M.E.

Chute, w 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

street

Dennis J. Chute no

111 Penn Street, Baltimore, Maryland 21201

26. Place of Death (Check only one)

Registrar

31. Date filed (Month, Day, Year) SEP 1 0 1997 32. Registrar's Signature

Wa Savidson Randale

DHMH 16 Rev 6/95

V

29d. Dete signed (Month, Day, Year)

Anne founded Co, Mol

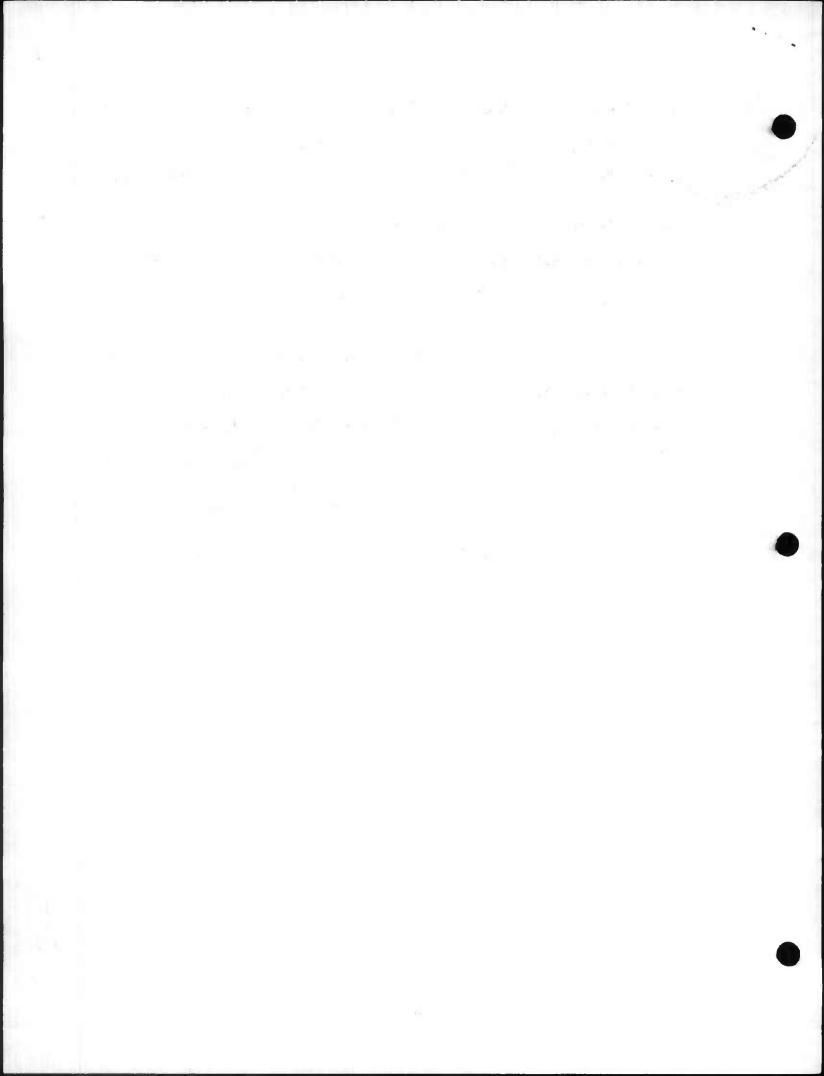
1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and marining as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

SEPT. 08, 1997

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 27367

| | | | | State of Ivial | | | te of Death | | Reg. No. | 1 41 | 301 |
|----------------|---|----------------|---|---|-----------------------------------|-------------------------------------|---|---|------------------------------------|---|------------------------|
| | Physic /Medi | | 1. Decedent's Name (First, Middle, Last | | ingto | N | | 2. Date of Dec Month SEP+ | Day | Yeer 1797 | 2 PM |
| | Exami | | 4a. Fecility Neme (If not institution, give | street and number) | 110010 | 1* | | or Location of Death | 4c. County | of Death | - 114 |
| | Funeral Director | | 5. Social Security Number 6. Se | TM 254E | In yrs. lest birthda Yrs. | y) If Und Months | Perry Hours 1 Year If Under 24 Hours M | | h v, Year) | 9. Birthplace (Country) Marylan | State or Foreign |
| | yland | | 10e. Stete 10b. County | 1 | 0c. City, Town or | Location | | | | 10d. In | side City Limits |
| | he Ma | Director | Md. Baltimor | e | Perry F | | | | | | Yes 2 No |
| | 3a or | | 5022 HILLTOP AC | re RJ | | 101. 2 | ip Code 21128 | | 10g. Citizen of N | What Country? | |
| 020 | d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 Is marked other than "naturel; or items 23s or 28s4 show traumatic event, the Medical Examiner must be notified at | by Funeral | 11. Maritel Status 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | er in U,S. 13 | 3. Was Dec If Yes, sp | edent of Hispanic Origin? ecify Cuben, Mexican, Pu | (Specify Yes or No- erto Rican, etc.) | | e - American Inc ck, White, etc. | |
| 21215-0020 | filed within 72 ho Hygiene. ther than "natur ent, the Medical | Completed | 15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) | cation e completed) College (1-4or 5+) | (Gi | ve kind of w . DO NOT | ual Occupation ork done during most of use retired) | | 16b. Kind of B | usiness/industry | |
| Maryland ; | should be filed and Mental Hyg is marked other sumatic event, | To Be C | 17. Father's Name (First, Middle, Last) HARRY Wallace Re | am | | CC 101 | | Name (First, Middle, | | | |
| Mar | d 2 sho h and 7 is me traum | | 19a. Informant's Name/Relationship (T) | 1 | 400 0 0 | | ss (Street and Number or | Rural Route Number | | |) |
| altimore, | es 1 an of Heal f item 2 r other | | 20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) | Removal from State | 20b. Place of Dis cemetery, co | position (Na rema <i>tory of</i> | Itop ACRE Roame of other place) | Sept 12 | Hall Mo 20c. Location - | City or Town, S | late |
| Balti | permit. Pag Department Important: If any Injury o | | 21. Signature of Funerai Service Licens | 2 | | 22. Name a | CHAPEL of | 1 emories | | larford R | સ |
| | J. Hora | | 23a. Part1. Enter the disease, or compi shock, or heart lailure. List only or | ications that caused the ne cause on each ine. | e death. Do not e | inter the mo | de of dying, such as card | liac or respiratory ar | | Appr | oximete val Between |
| | Physiclan /Medical Examiner | er | Immediate Cause (Final disease or condition resulting in death) | meter | e to (or as a cons | B4 | | ancer | | Onse | Months |
| ,00 | ificate be executed g physician and as the burial-transit | i Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Du | e to (or as a cons | equence of |): | | | i | |
| Box 68760, | E 0 6 | n/Medical | resulting in death) Last | Due | e to (or as a cons | equence of | : | | | | |
| | 0 0 0 | Physician/N | Part II. Other eignificent conditions cor | ntributing to death but n | ot resulting in the | underlying | cause given in Part I. | 23b. Did t | obecco use co | ntribute to the o | ause of death? |
| s, P.O | that the | by Phy | | | | | | 10 | 100 2V No | 3 Probably | 4 🗌 Unknown |
| Vital Records, | has be | eted | | | | | | | an autopsy rmed? | 24b. Were au available completi of death | prior to |
| al B | E ag ag | Сотр | | | | | | 1 🗆 1 | es 20(No | 1 ☐ Yes | 2)XN0 |
| | | o Be | 25. Was cese referred to medical examiner? 1 ☐ Yes 2 ☑ No | lospital: | 2 ER/Outpati | ient 3 🗆 🖸 | Othor | Death (Check only on Home 5 Residual) | | os (Engelha) | |
| ion of | al or Attending Phy s after death. I Director: After this d in by the funeral d | ation: T | 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation | 28a. Date of Injury (Month, Day Y | 28b. Time | | 28c. Injury at Work? 1 Yes 2 No | 28d. Describe h | | | |
| Division | To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined | 28e. Place of Injury building, etc. (| - At home, farm, s Specify) | street, facto | ry, office | 28f. Location (S City or Tow | itreet end Numb n, State) | per or Rurel Rout | e Number, |
| | To the Hospital within 24 hours a To the Funeral Completely filled | edicai | 29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examination | alcian: To the best of m nar: On the basis of ex and manner stated | amination end/or | ath occurred investigation | d at the time, date and plan, in my opinion, death o | ace, and due to the o courred at the time, | cause(s) and me date and place, | enner as stated. and due to the c | ause(s) |
| | To the within 2 To the comple | Me | 29b. Signature and title of certifier | | | 25 | c. License number | | 29d. Date signe | d (Month, Day, 1 | (ear) |
| | _ | | James (| 30per 1 | ~p | | D46118 | | Sept | 9 | 997 |
| | 10 | | 30. Name and eddress of person who co | PER IL | h (Item 23a) (Typ. +47 | e, Print) /OVK | RD Lu | thervil | e N | 10 2 | 1093 |
| | Sta Registr | - | 31. Date filed (Month, Day, Year) SEP 1 0 1997 | 32. Registrar's | Signature | | | | | | |



State of Maryland / Department of Health and Mental Hygiene

27368

TROY BRINSON Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** TROY BRINSON /Medical SEPTEMBER 8, 1997 ation of Death 4c. County of Death 01:45 AM 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location **Examiner** N/A STREET 1517 PRESSTMAN BALTIMORE 5. Sociel Security Number 6. Sex 1 M 2 □ F If Under 1 Year Birthplace (State or Foreign Country)
 NY 7. Age (In yrs. last birthday) Funerai Deys Months Hours 01/03/1971 Yrs. 26 Director 103-56-1649 Usual Residence of Deceden the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified tXYes 2∏No Director KING BROOKLYN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Items 23a 1191 PARK PLACE APT. 5H 11213 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Giva Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes XX No Specify BLACK by 3 ☐ Wirdowad 4 ☐ Divorced Completed the Medical 15. Decedent's Education 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elemantary/Secondary (0-12) Coltege (1-4or 5+) ENTREPRENEUR STREET PLAYER marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Department of Health and Mental Important: If Itam 27 Is marked or any Injury or other traumatic evenoses. EDWARD BRINSON ELAINE PADMORE 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) GLORIA BAKER/AUNT 1660 FULTON ST. APT. 5EE BROOKLYN, NY 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State W Burial 2 ☐ Cremetion 3 ☐ Removal from State CYPRESS HILLS 9/12/97 BROOKLYN, NY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licansea 22. Name end Address of Facility STERLING ASHTON FUNERAL HOME, INC. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. 736 EDMONDSON AVE. CATONSVILLE, MD 21228 Approximate Interval Between Onset and Death Physician a Multiple Gunsket Wounds Immediata Ceuse (Final disease or condition rasulting in daath) Examine Examiner Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disaasa or Injury that initiated evants rasulting In death) Last Dua to (or as a consequence of): Box 68760. ificate be Physician/Medicai tha Due to (or es a consequence of) 00 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by Records. 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 1 Yas 2 □ No Division of Vital Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certifica staly filled in by the funeral director, t Be 25. Was case raferred to madical 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) SCENE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1XYes 2 No 28d. Dascribe how injury occurred Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending subject shot 1 Yes 2 No 9-8-97 135 A-M investigation 2 Accident 6 Could not be datarmined Location (Street and Number or Gurel Route Number, City or Town, State) 15-17 Heastman St Saffinore, Md 3 Sulcide 28e. Placa of Injury - At hon building, atc. (Specify) At home, farm, street, factory, offica 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completaly filled in strey Baltimore, 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, data and plece, end due to tha cause(s) end manner es stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at the time, date and placa, and due to the cause(s) end manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME SEPTEMBER 8, 1997 antend 30. Nama and addrass of persop who complated causa of daath (Itam 23a) (Type, Print) ennist hute) MS 32. Ragistrar's Signature 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year) 1 0 1997

Julia Dividson Rando 80

State of Maryland / Department of Health and Mental HygieneQ Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month September 2, 1997 BUNN CHARLOTTE MAE FERRENS 8:00 A.M. /Medicai 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Rodgers Forge Baltimore

If Under 24 Hrs. 8. Dete of Birth Month, Dey, Year)

Hours Min. April 28, 1912 Maryland 6813-C Bellona Avenue If Under 1 Year Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1□ M 25 F 214-16-3958 Yrs 85 Director Usuel Residence of Decedent Peges 1 end 2 should be filed within 72 hours efter death with the Meryland nent of Health end Mental Hygiene. Int: If Itam 27 is marked other than "natural", or frems 23a or 28a-f show my or other traumstic event, it a Mexical Examiner must be notified at 10a State 10b Count 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Marvland Baltimore Rodgers Forge 10e. Street end Number 10f. Zlp Code 10g. Citizen of What Country? 6813-C Bellona Avenue 21212 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: 3 ₩ Widowed 4 Divorced White Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 years Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Jackson James Ferrens Alice Levina Ridgely 19a. fnforment's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 3753 Proctor Lane Baltimore, Maryland Bonita Lynn Hyle (daughter) 21236 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 XBuriel 2 ☐ Cremetion 3 ☐ Removal from State permit. Pege Depertment o Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) Lorraine Park Cemetery 9-6-97 Woodlawn, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facili Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212 se, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, List only one cause on each line. 23e. Pert1. Enter the disease shock, or heart failure Approximete Interval Between Onset end Deeth **Physician** /Medical fmmediete Ceuse (Finel STNOKE disease or condition resulting in death) Examiner Due to (or es a consequence of): Examiner The law requires that the death certificate be executed physician and the burial-transit Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of) USB as jo signed by the et d be detached fo Pert fl. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 | Yee 2 | No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24a. Was en autopsy performed? page 2 hes 1 Yes 2 No certificete 1 ☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how Injury occurred Certification: 28b. Time of 28c. fnjury at Work? 1 Naturel 5 Pending efter death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Sulcide 6 Could not be 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 24 hours Certifying Phyeician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) and manner stated. 29a, Certifier To the Hosp within 24 hou To the Funer completely fi Medicai 29d. Date signed (Month, Dey, Yeer) 29b. Signeture and title of certifier 29c. License number DBLSYS 30. Name end eddress of person who completed cause of death (Hem 23a) (Type, Print)

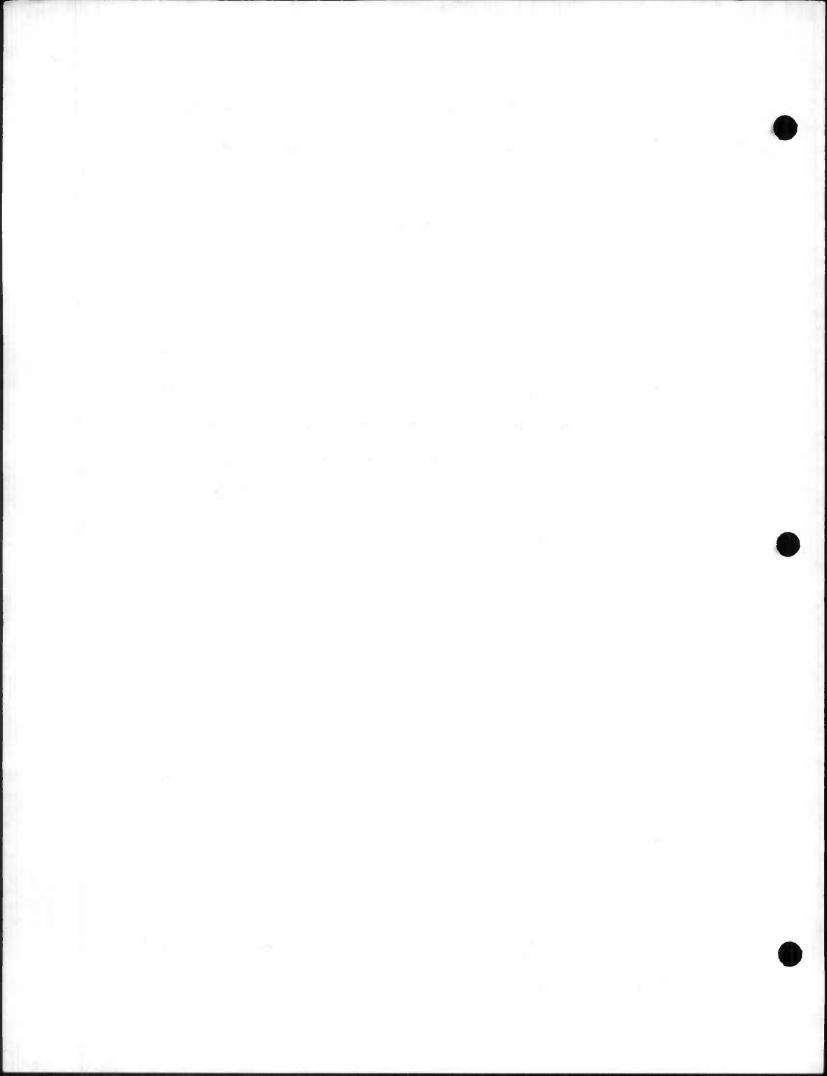
State

Registrar SEP 1 0 1997

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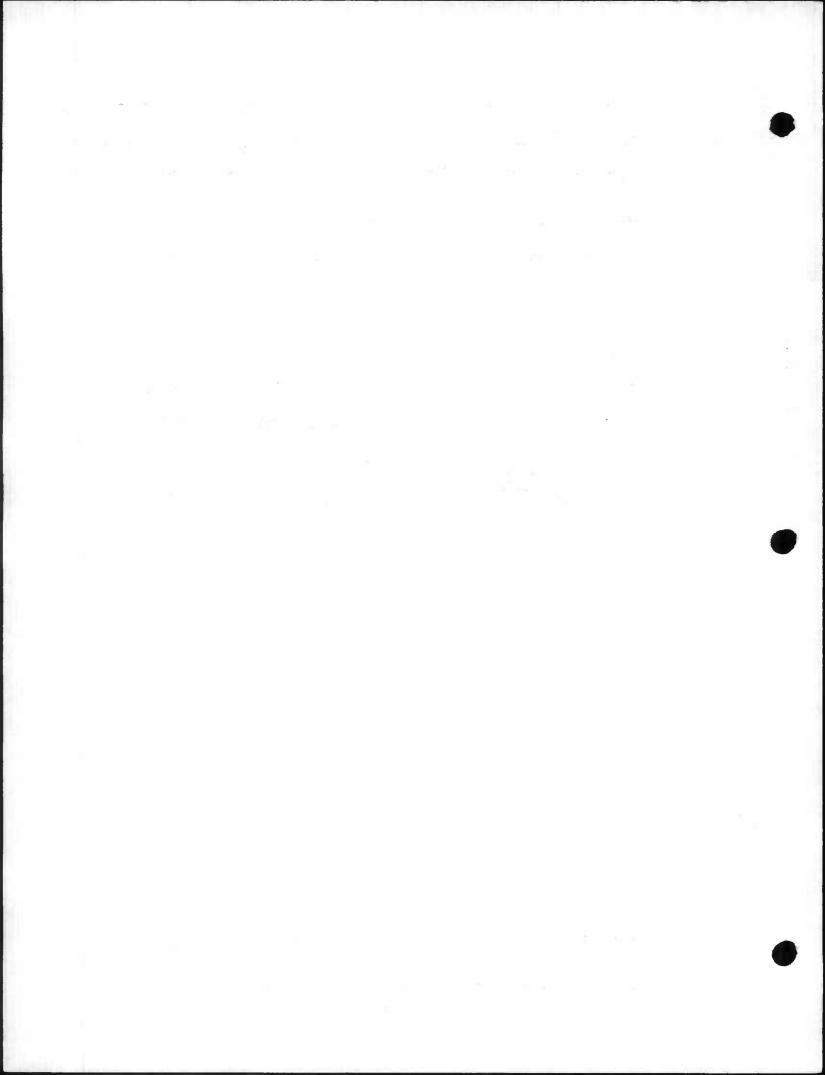
31. Dete filed (Month, Dey, Yeer)





State of Maryland / Department of Health and Mental Hygiene 97 27370

| | | | | | | Certificate o | of Death | | Reg. No. | | | |
|------------|---|----------------|--|---|------------------------|---|---|------------------------------------|------------------------|--------------------|--------------------------------------|----------------|
| | | | 1. Decedant's Neme (First, Middla, L | ast) | | | | 2. Data of D | eath | V | 3. Tima of De | ath |
| | Physici /Modi | | ELSIE | BENC | 1A | | | Month Septemb | er 5 19 | Yaar 997 | 12:30 p | m |
| 1 | /Medi Examir | | 4a. Facility Nama (If not institution, gr | | | | 4b. City, Town, o | r Location of Dee | | of Death | 4. | - |
| | LAUIIII | | STELLA N | PARIS | | | TIMON | iIIM | PA | Lto | | |
| | Funeral | | 5. Sociel Security Number 6. | | (in yrs. lest birtl | | er If Under 24 Hr | | | 9. Birth | piace (State or Fo | ora ion |
| | Director | | 065-07-9822 Usual Rasidance of Decedant | 1□M 2/X F | 83 | rs. Months Da | ys Hours Mi | 8. Data of Bi (Month, D 9-15 | ey, Year) -1913 | Mar | yland | |
| | yland M M | | 10e. State 10b. County | | 10c. City, Town | or Location | | | | | 10d. Inside City L | imits |
| | r 28a-f show notified at | Director | Maryland Har | ford | | Bel Air | L | | | | 1□ Yes 🌂 | |
| | death with the Maryland ms 23s or 28s-I show crivat be notified at | | 10e. Street and Number 622 Weatherby | Road | | 10f. Zip Cod | 2.1015 | | 10g. Citizan of U.S.A | | intry? | |
| | | Funeral | 11. Maritel Stetus | 12. Wes Decedant Ev Armed Forces? | ar in U,S. | 13. Was Dacedant of if Yes, specify C | of Hispanic Origin? | Specify Yas or N | o- 14. Rai | | can Indian, | |
| 21215-0020 | 72 hours after netural', or to dical Examine | by | 1 ☐ Navar Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced | 1 Yes 2 No If Yas, Giva Yaar or Dates: | | 1 □ Yas 2 N | | into Mican, atc.) | Specif | ck, Whita y: Wi | hite | |
| . G | 72 ho netur | eted | 15. Dacedant's E | ducation ada complated) | 16a. l | Decedant's Usuai Oci | cupation na during most of w | odeina | 16b. Kind of B | usinass/ir | ndustry | |
| 12 | filed within Hygione. ther than " ent, the Mes | Completed | Eiementary/Secondary (0-12) | College (1-4or 5+ |) | Give kind of work do life. DO NOT use ret Homemaker | | o.n.i.y | | 11 | | |
| | Hygio other t | | 9th grade 17. Fathar's Nama (First, Middle, Las | , | | 110memare | | ama (First, Middle | | wn H | ome | |
| Maryland | なほらき | Be | | ey | | | | lian | Manser. | | | |
| 2 | should be nd Merita marked imatle ev | 10 | 19a. informant's Name/Ralationship | | 106 | Mailing Address /Ctm | | | | | n Codel | Milet we where |
| Ma | DJ 65 40 44 | | Raymond L. Bendo | | | Mailing Address (Str 15 Tee Cou | | | | , Siere, Zi | p Code) | |
| è. | - P E E | | 20a. Method of Disposition | (8011) | 20b. Piace of | Disposition (Nama of | | Data | 21012 20c. Location | - City or T | own. Stata | |
| Baltimore, | Page nent c ant: If ury or | | 1 NBuriai 2 Cremation 3 C | (y) | cematary | od Cemete | ry | 9/8/97 | Baltim | 111 | Marylan | d |
| Ball | Departi Importa | | 21. Signature of Prineral Service Lice | nsub / | 5 | Schimun | dress of Fecility ek Funera | l Homes, | Inc. | 0.1.0 | | |
| | - | | 23a. Part1. Entar the disaasa, or cor | nplications that causad th | ha daath. Do n | | lair Rd., tying, such as cardi | | | 2123 | Approximate | |
| | Physiclan | | shock, or haart failure. List only | ona causa on aach line | | | | | | | intarval Betwee Onsat and Deet | n th |
| | /Medical | М | immediata Causa (Finai disaasa or condition | Recu | rring S | trokes | | | | 1 | | |
| | Examiner | | rasulting in daath) | a | | onsequence of): | | | | | | |
| | 7 5 | ner | | | | | | | | 1 | | |
| Ć. | the death certificate be executed y the attending physician and sched for use as the burial-transit | Examiner | Sequantially list conditions, if any, leading to immediata causa. Enter Undarlying | b | ua to (or as a co | onsequence of): | | | | i | | |
| 68760, | icate be physicla s the bur | edical | Causa (Disaasa or injury that initiated events resulting in daath) Lest | C. Du | ue to (or as a co | ensequenca of): | | | | i | | |
| × | eath certif attending I for use a | 2 | | d | | | | | | ! | | |
| Во | after 1 | clar | But Author wood on the | | | 2410-471-414-77 | -/ | 1 | | A | | |
| P.O. | that the death ed by the atte detached for | Physician/ | Part II. Other eignificant conditions | contributing to death but | not resulting in | tha undarlying cause | givan in Part i. | | | | to the cause of di | |
| 0 | s that | by P | | | | | | . 1L | Yes 2LINO | 3 Pro | bebly 4 Unit | nown |
| Records, | requires that een signed b | | | | | | | 24a. Wa | s an autopsy ormed? | 81 | are autopsy finditivallabla prior to | |
| Sec | has b | Completed | | | | | | | | of | ompiation of caus death? | Э |
| tal | # seg | | | | | | | 1 🗆 | Yas XX No | 1 | ☐ Yas 2☐ No | |
| 3/ | 1 2 | Be | 25. Was casa refarred to medical examinar? | Hamitai: | | | 100000000000000000000000000000000000000 | eath (Check only | ona) | | | |
| 4 | 344 S | T0 | 1 Yes 2 No | Hospitai: | | Datient 3LI DOA | | Homa 5 □ Ras | | | (ty) | |
| 8 | 2 2 | lon | 27. Mannar of Death 1 ☑Natural 5 ☐ Pending | 28e. Data of injury (Month, Day 1 | Year) 28b. Ti | | njuryat Vork? □ Yas 2 □ No | 28d. Describe | how injury occur | red | | |
| Si | Story The | cat | 2 Accident invastigation 3 Suicida 6 Could not to | De Diese of leive | . At home for | | | 29f Location | (Street and Num | harar D. | al Dauta Mumbar | |
| Division | after A Direct | Certification: | 4 Homicide dataminad | building, atc. | (Specify) | m, streat, fectory, offic | 28 | City or To | own, Stata) | oer or nur | al Route Number, | |
| - | spital neral | | 29a. Certifier 1/X Cartifying P | nysician: To the best of | mv knowledga. | death occurred at the | tima, date and piac | e and dua to the | causa(s) and m | anner as | stated | |
| | n 24 hour Funer e Funer pletely fill | edical | (Check only 2 Medical Exa | miner: On the basis of a and mannar state | xamination end | or invastigation, in m | y opinion, daeth occ | curred et the tima | , date end place, | and dua | to the causa(s) | |
| | To the Hospital within 24 hours To the Funeral completely filled | M | 29b. Signatura and titla of contifier | 100 | | 29c. Lice | D 15504 | 10.1 | 29d. Data signe | | | |
| | (6) | | | | | | D 10004 | | 7 7 | 17 | | |
| | () | | 30. Name and addrass of person who | | | • | D.7 - 1 | | | 2 | | |
| | | 40 | Eddie Nakhuda | | 0 Dular s Signature | ey Valley | Rd Tim | onium, M | id. 2109 | 3 | | |
| | Sta Registr | _ | 31. Data filad (Month, Day, Year) SEP 1 0 1997 | | ydson-Ro | ndall | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item 4c per FH Film Gu52 10-01-97 rja Certificate of Death 1 Decedent's Neme (First Middle Last) 2. Dete of Death Month Physician 4:45pm 7,1997 Jimmie Louis Blankenship Sept. /Medical 4e. Fecility Neme (If not Institution, give street and number, 4b. City. Town, or Location of Deeth 4c. County of Deeth HARFORD Examiner 2616 Jerusalem Rd. Kingsville Baltimore If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 8. Dete of Birth (Month, Dey, Year) Feb. 12, 1931 West Virginia 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Deys 1√2 M 2□ F 66 yrs Yrs. 234-46-6053 Director Usuel Residence of Dacedant 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or itema 23a or 28a-f show traumatic event, the Medical Examiner must be notified at HARFORD 1 ☐ Yes 2 ➡No Director Md. - Baltimore Kingsville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is merked other than "naturel; or Itema 28a any Injury or other traumatic event, the Medical Examinations. 2616 Jerusalem Rd. 21087 U.S.A. Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 14. Rece - American Indian, Bleck, White, etc. 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, atc.) 1 Never Married 2 Married 1 Yes 2 No If Yes, Give • Specify: White 1 ☐ Yes Z No Specify. þ 3 ☐ Widowed 4 ☐ Divorcad Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elamentary/Secondery (0-12) College (1-4or 5+) 12yrs Cmo-toll facilities State Employee 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) John Walter Blankenship 0 Lucille Christain 19e. Informent's Name/Ralationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) Janet Blankenship/wife 2616 Jerusalem Rd. Kingsville Md. 21087 20b. Pleca of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Data 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State Holly Hill Cem. 9 - 10Middle River, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Fungral Service License 22. Name end Address of Fecility Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. Dundalk Md. 21222

Approximeta on each line.

7110 Sollers Point Rd. Dundalk Md. 21222

Approximeta Approximeta Intervel Batwaan Onset end Deeth disease, or complication failure. List only one ca **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting In deeth) Examiner Due to (or es e consequence of) Examiner physician and the burial-fran Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cousa (Disaasa or injury that initiated avants resulting In deeth) Lest Dua to (or as a consequence of) cian/Medicai the Dua to (or as e consequence of) for use as Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara eutopsy findings avelleble prior to completion of cause of death? 24e. Wes en eutopsy performed? ped page 2 certificate has 1 ☐ Yes 2 No 1 Yes 25 No director, 25. Was case referred to medical exeminar? Be 26. Pleca of Daeth (Check only ona) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28d. Dascribe how Injury occurred Certification: 28b. Time of 28c. Injury et Work? Natural 5 Pending Investigation 1 ∏ Yes 2 □ No 2 Accident 3 Sulcida

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed Hospital or Attanding Physician: after death To the Hospital or Atta within 24 hours after de To the Funeral Diracto completely filled in by the

with the Maryland

Baltimore, Maryland 21215-0020

J

edical

31. Deta filad (Month, Day 97 Registrar

4 Homicide

29a. Certifier

29b. Signature

6 Could not be datamined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Pleca of Injury - At homa, farm, straet, factory, office building, atc. (Specify) Cartifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29c. License number 29d. Date signed (Month, Dey, Year)

D26835

30. Neme and eddrass of person who co

State of Maryland / Department of Health and Mental Hygiene

97 27372

| | | | | | | Ce | rtificate o | f Death | | Reg. No. | 21 | 61016 |
|---------------|---|------------------|---|--|--------------------------|-------------------------------|---|--|---------------------------------------|-----------------------------------|--|-------------------------------------|
| Γ | Physic | ian | 1. Decedent's Name (First, Middle, | .ast) | | | | | 2. Date of De | eeth Day | Yeer | 3. Time of Death |
| ı | /Medi | | CONNIE | | | | 80 | STICK | Sept | , | 03 97 | 16:48 |
| | Exami | ner | 4e. Fecility Neme (If not institution, g | | | | | 4b. City, Town, or I | Location of Deat | h 4c. Count | y of Deeth | |
| | | , . | The Johns Ho | pkins H | lospita | 1 | | Baltimo | | - | NA | |
| | Funeral Director | | 215-24-0927A | Sex 1□M 2□F | 7. Age (In yrs. la 81 | rst birthday) Yrs. | If Under 1 Yas Months Dey | | 8. Data of Bir (Month, Da 04-0 | | 9. Birthp Coun | piece (State or Foreign htry) |
| | and * | | Usuel Residence of Decedent 10a. State 10b. County | | 10c City | Town or Lo | cation | | | | 14 | Od. Inside City Limits |
| | lanyl sho | 5 | Md NA | | | ltimo | | | | | | 1√2 Yes 2 □ No |
| | the A | ect | 10e. Straat and Number | | | | 10f. Zip Code | | | 10g. Citizan of | M/hat Caus | |
| | 23e or | Funeral Director | 1836 North Bo | nd Stre | et | | 2121 | | | USA | vvnet Coun | try r |
| 21215-0020 | 172 hours after death with the Maryland "natural", or itema 23a or 28a-f show lotes! Examinet must be notified at | by | 11. Maritel Stetus 1 Navar Married 2 Married 3 Vidowed 4 Divorced | Armed Fo | 3∏No | | Ves Decedent of f Yes, specify Cu 1 ☐ Yes 2 및 N | Hispenic Origin? (Siben, Mexican, Puerti o Specify: | pecify Yes or No o Rican, etc.) | 9- 14. Rei Bia Specif | ce - Americ ick, White, fy: Bla | etc. |
| 5-0 | in 72 ho | ě | 15. Decedent's (Specify only highast of | Education | | 16a. Deced | dent's Usuel Occ | upation | kina | 16b. Kind of B | | |
| 2 | 5 5 | Completed | Elementery/Secondary (0-12) | Collaga (1 | -4or 5+) | | | e during most of wor red) | | | | |
| 7 | filed with Hygiene. ofther than | S | 10th Grade | NA | | Fost | er Car | e Provid | | | Home | |
| 2 | | Be | 17. Fether's Neme (First, Middle, La. | • | | | | 18. Mother's Nen | ne (First, Middle | , Maiden Sumar | me) | |
| Maryland | | 2 | Ben | McW | hite | | | Mary | | Hunt | | |
| Ja | V 0 0 0 | | 19a. Informent's Name/Reletionship | | | | | et and Number or Ru | | | | |
| | f Heelth fem 27 other tr | | | vis | | | | squith S | Street | Baltin | nore, | - |
| 5 | 8 2 2 | | 20e. Mathod of Disposition 1 | □Removel from 5 | | ece of Dispo metery, crer | sition (Name of natory or other p | lace) | Date | 20c. Location | - City or To | wn, State Md |
| baltimore, | | | 4 □ Donetion 5 □ Other (Spec | | | rison | Fores | t VA Cen | n. 09-6 | 9-97 | Owing | s Mills |
| | Department Personal Important any Injury | | 21. Signature of Funeral Service Lib | onsee | .0 | 22 | . Name end Add | ress of Fecility Bal | ltimore | a. Mars | rland | 21202 |
| D | 88 5 8 | | the state of h | . A. | att. | r c | M.C. M | larch FH | 1101 | Nort | h A | 21202 |
| | | | 23a. Partt. Briter the disease, or co shock, obsert feilure. List on | Aplications that or | suped the death. | | | | | | II AV | Approximate |
| | Physician | | snock, ordeer fellure. List on | y one ceuse on e | ach line. | | | | | | i | Interval Between Onset and Death |
| ŧ. | /Medical | | Immediete Ceuse (Finel diseese or condition | | COPER | LARU | ARTE | DY NTSE | EASE | | 1 | 4 days |
| | Examiner | | resulting in death) | θ | | as e conseq | | (01 023 | | | | 1 010073 |
| _ | | Je | | | 220 (0 (0. | | 301100 017. | | | | 1 | |
| | sertificate be executed ding physician and se as the burial-transit | Examiner | Sequentielly list conditions | b. — | Due to (or | es e conseq | uence of): | | | | | |
| ć | an ar | | Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or Injury | | (- | | | | | | | |
| 00/00 | ysicil be bu | edicai | thet initiated events | C | Dua to (or | es a conseq | uance of): | | | | | |
| | tifica ng ph | Pe | resulting in deeth) Last | | (0) | | | | | | i | |
| 200 | 6 3 | M/us | | d | | | | | | | 1 | |
| 200 | ath atte | SICI | Part II. Other significant conditions | contributing to de | eth but not resul | ting In the u | nderlying cause o | iven in Pert I. | 23b. Did | tobacco usa co | ntribute to | the cause of death |
| 2 | b A | Physician | | | | | , , , , | , | | Yes 2 No | | pably 4 ☐ Unknow |
| | 113 | by | - Clabeles | | | | | | | | | |
| Vital Records | 6 D | | Diabetes Hypertensi | | | | | | | an autopsy med? | 24b. We | ere autopsy findings |
| Š | as be | Completed | Hyper Teusi | CN | | | | | pone | ATTIOUT | cor | mpletion of cause death? |
| Ĕ | 0 4 8 | E O | | | | | | | 10 | Yas 2 No | 1 | Yes 2 No |
| <u>ra</u> | deligen: The | BeC | 25. Wes case referred to medical | | | | | 26. Place of Dea | | | | 1165 20110 |
| > | | To B | examinar? 1 ☐ Yes 2 No | Hospital: | npatient 2 E | R/Outpatien | t 3 DOA | ther | ome 5 ☐ Resi | | or /Coorie | -1 |
| 5 | 문 등 교 | | 27. Manner of Daath | 28a. Date o | of Injury : | 28b. Time of | 28c. Inj | | | how injury occur | | 9 |
| 5 | tending P death. tor: After I the funer | tioi | Naturel 5 Pending 2 Accident Investigati | | h, Day Year) | Injury | | ork? ☐ Yes 2 ☐ No | | | | |
| DIVISION | or Attending after death. Director: After d in by the fune | Certification: | 3 ☐ Sulcida 6 ☐ Could not | 28e. Piece | of Injury - At hon | ne, ferm, str | eet, fectory, office | 9 | | | ber or Rura | l Route Number, |
| 5 | 2 5 C | ert | 4 Homlcide | buildir | ng, etc. (Specify) | | | | City or To | wn, State) | | |
| | To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by | edical C | 29a. Certifier 12 Certifying F (Check only one) | hysician: To the miner: On the ba and mann | sls of examinetic | ledge, death on and/or inv | occurred et the restigation, in my | time, dete end place, oplnion, deeth occur | , end due to the rred et the time, | cause(s) end m date end plece, | anner as st and due to | ated. tha cause(s) |
| | vithin of the | Me | 29b. Signeture and title of certifier | | | | 29c. Lice | nse number | | 29d. Date signe | ed (Month, I | Day, Year) |
| | ->-0 | | June 1 A | No. | | 115 | 1" | LES-DOC | | 01 | 9/9- | 1 |
| , | ,\ | | 30 Name and address of sever (II) | TUUUTK | and don't fire | (117 | | | | | 111 | |
| | V | | 30. Neme end address of person with | completed cause | or deeth (item : | zsa) (Type, | ^{-rint)} 60 | 0 North | Wolfe | Street | Bal | to., Md. |

J. NEWCOMER, MD

32. Registrer's Signeture

SOHNS HOPKINS HOSPITAL

TOWER 110

DHMH 16 Rev 6/95

State Registrar GERARD

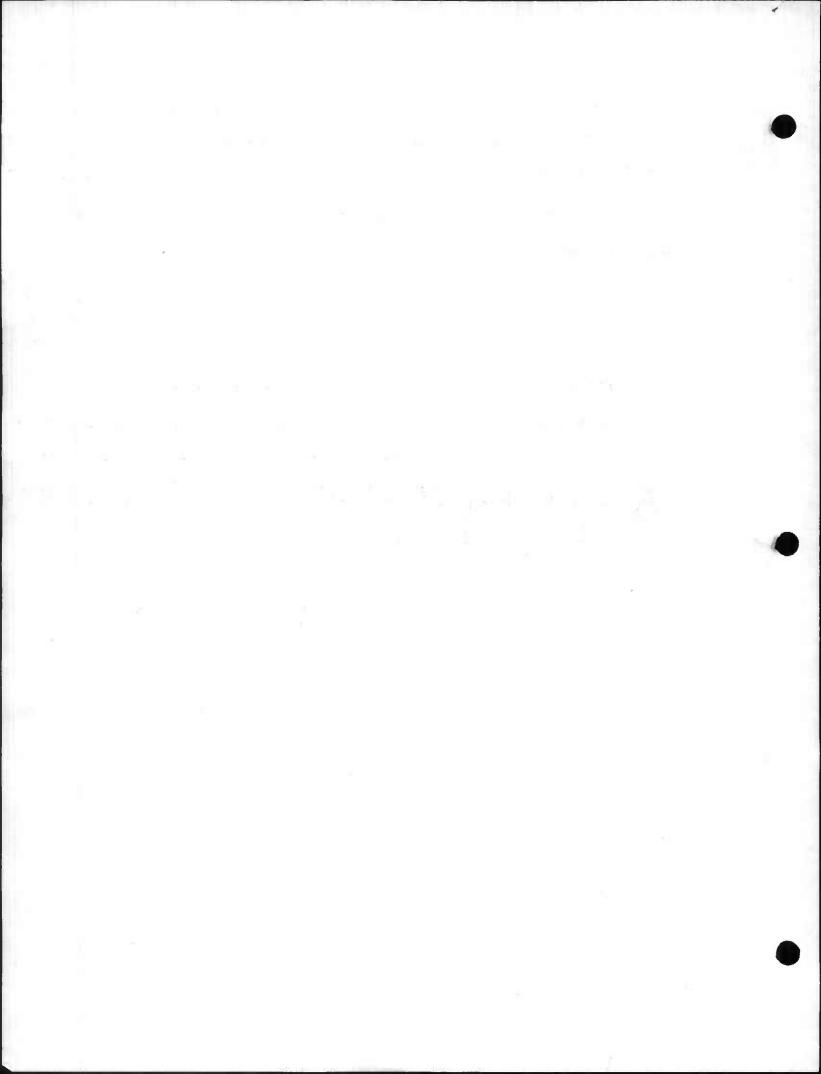
31. Dete filed (Month, Day, Year) SEP 1 0 1997

State of Maryland / Department of Health and Mental Hygiene 97 27373

| | | | | | Cei | rtifica | te of | Death | | R | eg. No. | | - 10 | ,,, |
|--|----------------|--|--|--------------|--------------------------|------------------------|-----------------------|------------------------------|-----------------------|---|----------------------------|------------------------------|--------------------------------------|---------------------|
| | | 1. Decedent's Neme (First, Middle, La | st) | | | | | | | 2. Dete of Deat | th | | 3. Time | e of Deeth |
| Physic /Med | | JAMES H. BI | ROWN | | | | | | | Month August | 30, | Year 1997 | 7:2 | 25 pm |
| Exami | | 4e. Fecility Name (If not institution, giv | e street and number) | | | | | 4b. City, To | wn, or L | ocation of Deeth | 4c. Count | y of Deeth | | |
| | | 4025 FREDERIC | K AVE., A | APT. | 314 | | | BAI | TIM | ORE | | N/2 | 4 | |
| Funeral Director | | 5. Sociel Security Number 6. S 218-03-9427 | ex 7. Age | (In yrs. les | t birthdey) Yrs. | If Unde Months | Days | | 24 Hrs. Min. | 8. Date of Birth (Month, Dey, | Year) 1520 | 9. Birthpl Coun | | te or Foreign |
| D . | | Usuel Residence of Decedent | | | | | | | | 07 | . / | 1701 | . 9 1 4 | 11 (4 |
| how | _ | 10e. State 10b. County | 1 | 10c. City, | | | | | | | | 10 | Od. Inside | e City Limits |
| e Ma | cto | MD N/ | A | | BAI | TIM | ORE | | | | | | 1,2 Y | res 2□No |
| or 2 | Director | 10e. Street end Number | | | | 10f. Zi | p Code | | | 10 | 0g. Citizen of | What Coun | try? | |
| 23a | la la | 4025 FREDERIC | K AVENUE | | | | 2 | 1229 | | | U . S | S.A. | | |
| tom Tom | Funeral | 11. Marital Status | 12. Was Decedent E Armed Forces? | | 13. \ | Was Dece f Yes, spe | edent of ecify Cut | Hispanic Ori en, Mexicar | igin? (Sp | ecify Yes or No- Rican, etc.) | | ca - America ck, White, e | | 1, |
| n 72 hours after death with the Maryland "natural", or flems 23a or 28a-f show soldal Examiner must be notified at | by | 1 ☐ Never Married 2√€ Married 3 ☐ Widowed 4 ☐ Divorcad | 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: | • | | I□ Yes | | | | | Specif | | lack | |
| 72 ho | ted | 15. Decedent's Ed | | | 16e. Deced | lent's Usu | al Occu | pation | A mill committee | 100 | 16b. Kind of B | usiness/Ind | lustry | |
| - | Completed | (Specify only highest gre Elementery/Secondary (0-12) | College (1-4or 5+ | -) | | | | during mos | t or work | aing | U.S. | Post. | a 7 . | Servi |
| Agien fr. th | 50 | 6th | | | Ope | rato | or | | | | | 1000 | | JCI VI |
| nould be filed withing Mental Hygiene. marked other than matic event, the Mental Ment | Be | 17. Fether's Name (First, Middle, Last) | | | | | | 18. Mothe | er's Nem | e (First, Middle, M | Aaiden Sumer | ne) | | |
| should be and Menta marked umatic en | 2 | John Brown | | | | | | | Mau | de Bro | wn Lan | dmon | | |
| S L S | | 19e. Informant's Name/Reletionship (| Type, Print) | | 19b. Mailin | g Addres | s (Stree | t end Numbe | er or Rur | al Route Number, | City or Town | , Stete, Zip | Code) | |
| F | | Sally A. Brow | n | | 11112 | Se | min | ole A | ven | ue, Ba. | lto., | MD | 212 | 29 |
| 5 5 2 | | 20a. Method of Disposition 1 ☐ Buriai 2 🛣 Cremation 3 ☐ | Demousi from State | 20b. Plac | e of Dispo | sition (Na | me of other ple | ece) | 1 | Date | 20c. Location | - City or To | wn, State |) |
| Pages nent of int: If its ury or o | | 4 Donetion 5 Other (Specify | | | ro C | | | | 1.5 | 9/6 | Bal t | imor | e, l | MD |
| permit. Page Department of Important: If any Injury or once. | | 21. Signature of Funeral Service Licer | (P) | | 1 22 | . Name e | nd Addr | ess of Fecilit | y_ | | | | | |
| SOFES | | JON MIL | 1) 11/1 | 01 | | | | | | & SON I | | | | |
| | | 23a Part Letter the disease, or company of heert failure. st only | plications that caused | he death. | not ente | er the mo | de of dv | Ing. such es | cardiec | or respiratory arre | st. | BALTC | Approxin | |
| Physician | | shook of heart failure. List only | one ceuse on eech in | 1 | | | | | | | | | Interval I | Between nd Deeth |
| /Medical | | Immediete Cause (Final | 01 | . 00 | | | 0 | n | | 0 | | | | |
| Examiner | | disease or condition resulting in deeth) | . Cham | 061 | me | twe | Va | lmon | con | Vifeas | 1 | 2 | ewer | d years |
| | ē | | U | Due to (or e | s a conseq | uence of) | 1: | | , | | | | | |
| certificate be executed ding physician and se as the burial-transit | Examiner | Conventingly, liet conditions | b | ue to (or e | | uonon of | | · | | | | | | |
| exec in an ial-tr | EX | Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying | | 10 (0) 6. | ~ | uerice or) | • | | | | | | | |
| certificate be executed rding physician and use as the burial-transit | Medical | cause. Enter Underlying Cause (Diseese or injury that initieted events | c | ue to (or es | e consequ | uence of): | | | | | | | | |
| oph as th | ed | resulting In death) Lest | _ | 00 10 (0. 00 | | | | | | | | | | |
| | | | d | | | | | | | | | | | |
| death o | icla | Pert II. Other significant conditions or | entributing to death but | not resultin | no In the ur | derlying | COLLEG D | ven in Pert I | | 23h Did to | bacco uae co | ntribule to | the cour | ne of death? |
| the the | Physician | Total organization | | not resum | ig in the or | denying | Cause y | Agit iii L Gif I | | 1 12 4 | | | | Unknown |
| that ed b deta | by P | | _ | | | | | | | 10014 | 2 2 140 | 3 - 100 | auty - | _ OHKHOWH |
| 1 2 4 | | | | | | | | | | 24e. Wes ar | n autopsy | 24b. We | re eutop | sy findings |
| 1 | Completed | | | | | | | | | perform | ned? | con | illable pri npletion of feeth? | |
| 2 8 | E | | | | | | | | | | | | | 1 |
| N. Peet | | 05 144 | | | | | | | | 1 ☐ Ye | | 1 | Yes 2 | 2 No |
| licia certi | Be C | 25. Wes case referred to medical examiner? | Hospitel: | | | | Ot | her: | | h (Check only one | | | | |
| Phys at di | : To | 1 Yes 2 No 27. Menner of Deeth | 1 ☐ Inpatien 28e. Dete of Injury | | Outpetien b. Time of | | υ Λ | 4 🗆 140 | | me 5 Passide | | 1-1 |) | |
| After | ion | 1 Naturel 5 ☐ Pending | (Month, Day | Year) | Injury | м | 28c. Inju Wo | rk?]Yes 2∐I | | 28d. Describe ho | w injuly occur | red | | |
| Attending ir death. ector: After by the fune | Certification: | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be | | At home | form stre | | | | - | 29f Location (Ct | root and Numi | has as Burni | Doute N | humbar |
| 유원들도 | arti | 4 ☐ Homicide determined | building, etc. | (Specify) | s, rem, suc | et, rector | y, office | | | 28f. Location (Str City or Town | , Stete) | oer or Hurar | HOUSE IV | umber, |
| ospitat o hours a uneral D by filled i | | 29a. Certifier 1 Certifying Phy | relation. To the heart of | | d d n. | | | | | | | | - | |
| Hospital 24 hours Funeral etsly filled | edicai | (Check only one) | reician: To the best of liner: On the basis of e | xamination | age, deeth end/or inv | occurred estigation | at the to | me, date en opinion, deel | d piece, th occurr | end due to the ce ed et the time, de | use(s) and mete end plece, | enner as sto end due to | ated. the caus | e(s) |
| To the Hos within 24 h To the Fun completely | Me | 29b. Signeture and title of certifier | end manner state | ed. | | 20 | c I leen | se number | | 7.00 | ad Data signa | d (Month I | Day Von | e) |
| E 3 F 8 | | Ac- | | | | | | | | | d. Dete signe | | | , |
| . 0 | | Pot | T ms | | | | 0 13 | 8317 | | 5 | sept. | 3, 19 | 97 | |
| 10 | | 30. Name end eddress of person who | | | | | | | | | | | | |
| , | | BERNARD P. FA | RRELLMI | 2 110 | 22 M | TTLE | PA | THEN | TYX | cwy, col | umBIA | mo. | 2104 | +4 |
| Sta | ate | ST. Day FP Month Day (197) | guta Dans | s Signature | and De | | | | | | | | | |

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death (arrie 4b. City, Town, or Location of Deeth pm 4a. Facility Name (If not institution, give street end number) 4c. County of Deeth Baltimore Na Maryland 5. Social Security Number General HOS ortal If Under 1 Year Age (In yrs. lest birthday) If Under 24 Hrs. 9. Birthplace (Stete or Foreign Gountry) 1□M 212F Months Deys Hours Min. 220-14-6274 Usual Residence of Decedent Yrs. irainia 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Na 1 PYes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ane Brooks 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indian, Bleck, White, etc. 11. Maritel Status 1 ☐ Yes 2 12 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□ Yes 2₽No Specify: Specify: Black 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) actory worker 17. Fether'ş Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) ler annie 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Son Charles D. Bagley 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removel from Stete ern 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensee 22. Name and Address of Facility
JOSEPH L. RUSS funeral Home
22.22 w. north ave, Baltimore, Md. 21216 23 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Ceuse (Final espirator. disease or condition resulting In death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dimpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Yeer) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury et Work? 1 Neturel 5 Pending Investigation 1 ∏Yes 2 ∏No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

The lew requires that the death cartificete be executed P.O. Box 68760, Division of Vital Records. Hospital or Attending Physician: **Physician**

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Examiner

Funeral

Director

28a-f show

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traumatic event, the Medical Examiner namt be nutified at

pernit. Pages 1 and 2 should be filed within 72 hours efter death 1 Department of Health end Mental Hygiene. Important: If Nem 27 is marked other than "natural", or frems 23, any injury or other traumatic event, trailled

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24 hours efter death ■ Funeral Director: A

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Certification: To

Medical

Baltimore, Maryland 21215-0020

State Registrar

31. Date filed (Month, Dey, Yeer)

4 Homicide

29a. Certifier (Check only one)

Houses / eff inter

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year)

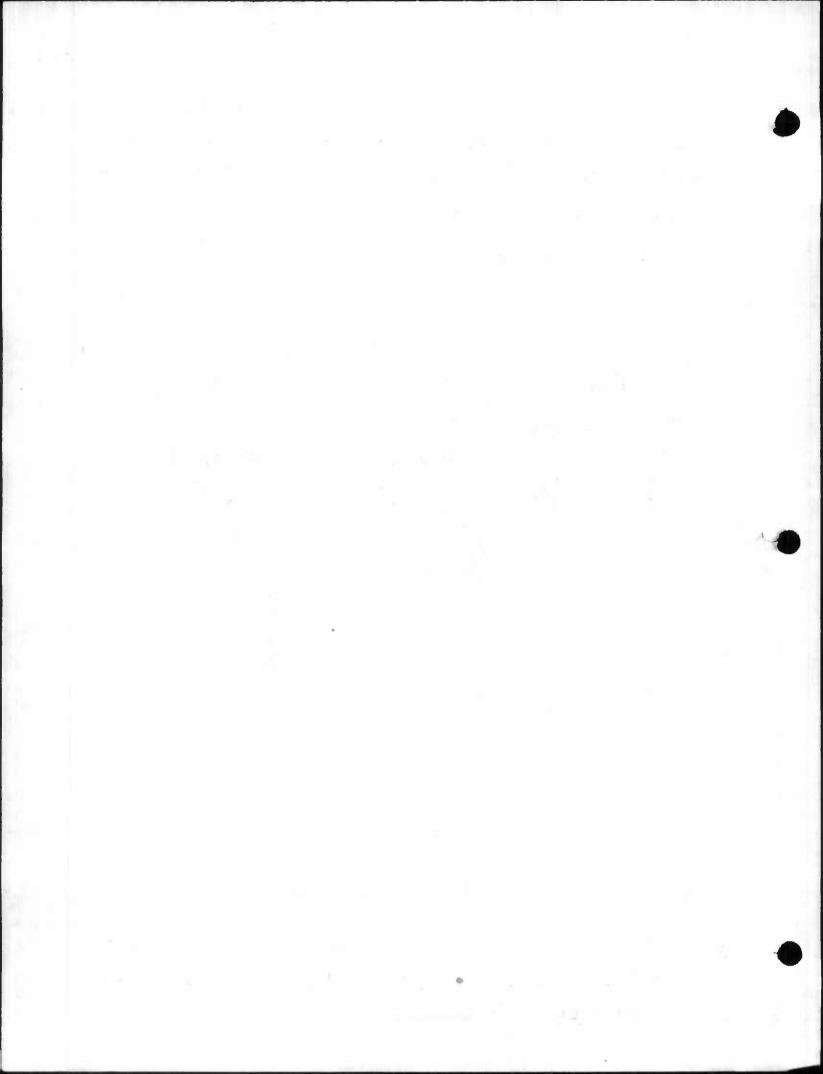
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ama m.D.

Taryland Greneral

29b. Signature and title of certifier

Dames

32. Registrar's Signature Alia Davidson



Funeral Director d 2 should be filed within 72 hours after th and Mantal Hygiane. 7 ie marked other than "natural", or Nei traumatic event, the Madical Examines 21215-0020 Maryland Pages 1 and 2 should be fill ment of Health and Mantal Hant: if Item 27 is marked oth jury or other traumatic even Baltimore,

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Depentment of Important: If any Injury or

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Physician Examiner 68760 o Records, Vital of Division

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year Baker September 1,1997 4:51 mm Robert 4a. Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Dete of Birth
Months Days Hours Min. (Month, Day, Year) 6. Sex 10 M 2□ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 218-44-3874 50 Yrs. Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits Balti nove Battimo 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 212129 STREET 45. 3 WILLARD 12. Wes Decedent Ever in U,S. Armed Forces? 1 Deceded to the Second of Yes, Give Year or Detes: 14. Race - American Indien, Black, White, etc. 11. Maritel Stetus Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 200 Married 1 ☐ Yas 2 No Specify: Specify: BLK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedant's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WATER MERCHANT SEAMON 12 2 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) BAKER MAIlIE K. DELORES SMAILWOOD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) GERALDINE BAKER (WIFE 3 WHELLER ST. DACTIMORE, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 9/5/97 CROWNSVILE, MD CROWNSUITE UET. CEMT. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility E. L. Phillips TUNERAL HOME 21. Signature of Funeral Service Licenses Decta CFSP 1721-27 N. MONROE ST. BALTIMORE, MD 21217 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death tmmediate Cause (Final disease or condition resulting In death) a Disseminated Intravascular Cooquiation ~ 12 hrs Due to (or as a consequenca of): 3rd 1 day 85%0 degree burns Donald & Wingh MD Sequantially list conditions, if any, laading to immediate cause. Enter Underlying Causa (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contributs to the cause of death? 1 No 3 Probably 4 Unknown 24b. Were autopsy findings 24a. Was an autopsy available prior to completion of cause of death? 1 Yes 2 No 1 Yas 2 No 26. Place of Death (Check only ona) Hospital: 1 Unpatient 2 ER/Outpatient 3 DOA Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury et Work? 1 Natural 5 Pending investigation 8-31-97 8:00 A M 1 Yes 2 No 2 Accident house fire 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician/Medical Examiner Be Certification: To

Completed by

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State

Registrar

29a. Certifier

(Check only

physician and the burial-transit 8 980 page 2 certificata this funeral Attending s efter deeth.

I Director: Aft
od in by the fur 0 Hospital 24 hours

25. Was case rafarrad to medical examiner? 18 Yes 2 No 27. Manner of Death

4 I Homicide

6 Could not be determined

28a. Place of tnjury - At home, farm, straet, fectory, office building, etc. (Specify) home

21224 2000 Silver Ct 150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of

MABS FRACS 30. Nama and andress of purson who complated causa of death (Itam 23a) (Type, Print)

MEDICAL

29c. License number

29d. Dete signed (Month, Day, Year) September 3, 1997

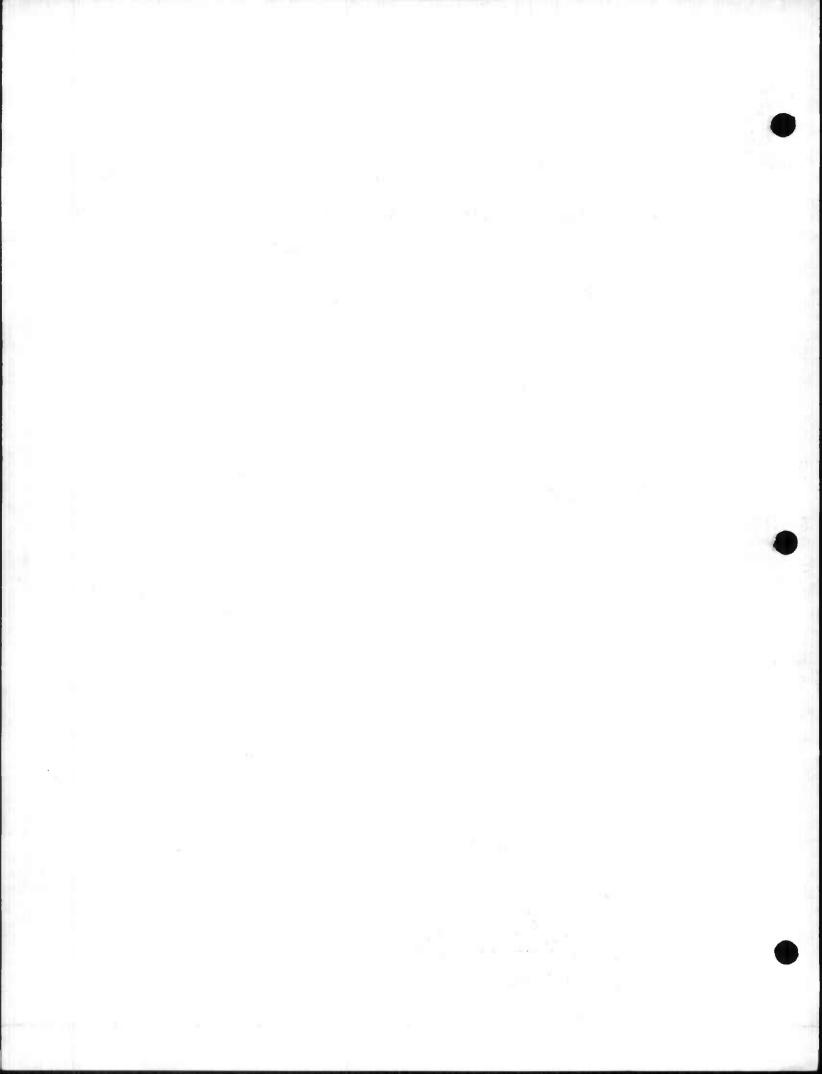
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3 Ragistrar's Signature rule Devidson Randelle

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To the Hosp within 24 hor To the Fune completely fi



68760. Box (P.O. Records. Division of Vital

> State Registrar

29b. Sla

AKON 31. Data filed (Month, Day, Year) SEP 1 0 1997

and address of person who complated cause of death (Itam 23a) [YP] Pripenn Street, Baltimore, Maryland 21201. 32 Registrar's Signatura Filia Davidson-Randose

29c. License number

O.C.M.E

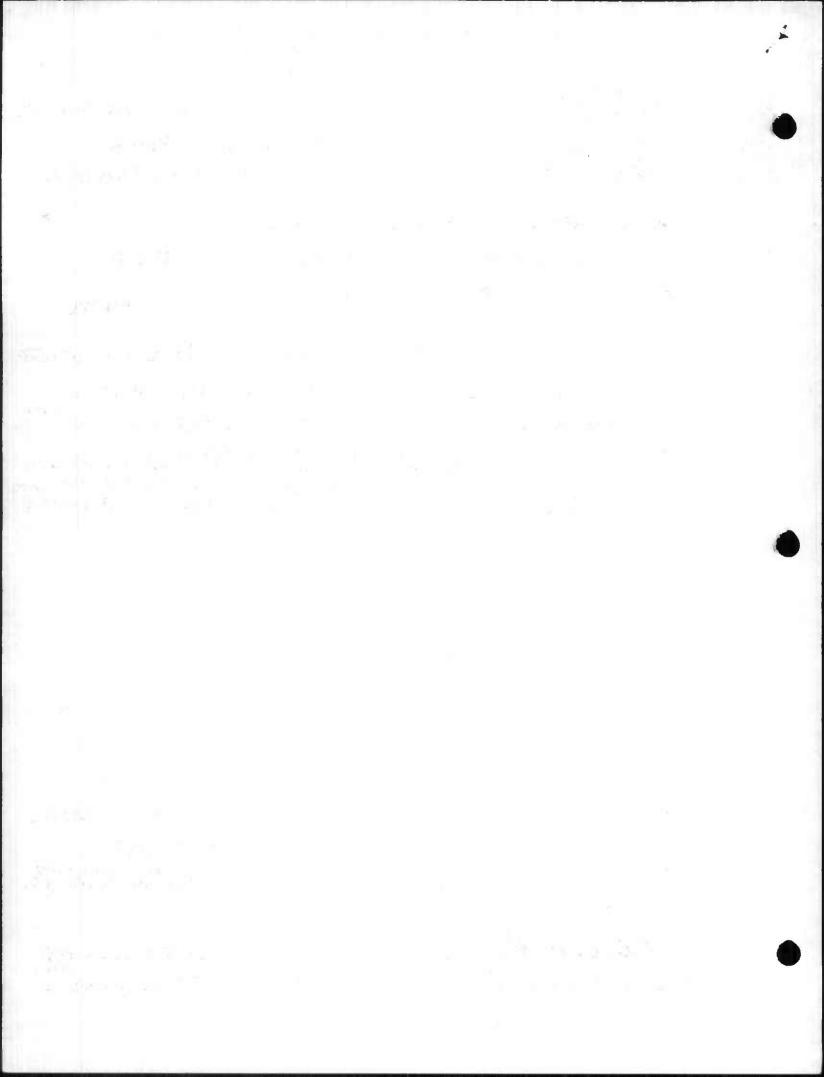
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State of Maryland / Department of Health and Mental Hygiene 0.7

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| | ieaic amin | - 40 | 4a. Fecility Neme (If not institution, giv | e street and number) | SACH | ROAD | | 4b. City, Town, or をOしをい | Location of Deet | | of Deeth | 30 | | |
| Fune Direc | | | 5. Sociel Security Number 6. S | ex 7. Age | (In yrs. last bi | rthday) If Unde Months | er 1 Year | If Under 24 Hr Hours Min | 8. Dete of Bir | th ly, Year) 3 1965 | 9. Birthpled Country | Se (State or Foreig | | |
| Maryland H show | 10 70 | tor | 10a. Stete 10b. County OARNAM HARE | ENRO | 10c. City, Tow | | s (: | RACS | | | 10d | . Inside City Limit | | |
| with the | Loe not | I Director | 10e. Street end Number | | | | ip Code | | | 10g. Citizen of | What Country | 7 | | |
| 72 hours after death with the Maryland "natural", or items 23s or 28s-f show | Name of the state | by Funeral | 11. Maritel Status 12. Never Married 2 Married 3 Widowed 4 Divorced | 12. Wes Decedent E Armed Forces? 1 Yes ZEN If Yes, Give Yeer or Detes: | | 13. Wes Dece If Yes, sp | | lispenic Origin? (en, Mexicen, Pue | Specify Yes or No rto Rican, etc.) | 14. Rec Ble | ce - American ck, White, etc | | | |
| within ene. then | Die Medical L | Completed | 15. Decedent's Ec (Specify only highest gra | lucation de completed) College (1-4or 5- | | life. DO NOT | ork done | during most of wo d) | orking | 16b. Kind of B | | STRACT | | |
| be filed tal Hyg d other | 2 | To Be C | 17. Fether's Neme (First, Middle, Last) | Zown, III | | | | | me (First, Middle, | | 31.14 | 12 | | |
| permit. Pages 1 end 2 should Depertment of Health end Mer Important: If Item 27 is marke any Inlury or other tranmetic | injury or outer | - h | 19e. Informent's Name/Reletionship (20a. Method of Disposition Buriel 2 Cremetion 3 C 4 Donetion 5 Other (Specifications) | SARILLS Removel from State | 3 20b. Plece of | Disposition (Nany, crematory or | ame of other pla | BAMEST BES OF FOOIIITY UNERCL | 1961 | 20c. Location OUGL Constitution | ARYLE | 100 | | |
| Physicia /Medic Examin | cai ner | Iner | 23e. Pert1. Enter the disease, or com- shock, or heart feilure. List only Immediate Ceuse (Final disease or condition resulting in deeth) | · buns | 101 | |) Q' | | | rrest, | In | pproximate tervel Between nset end Deeth | | |
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| certifically inscion, page | out, page | | 25. Wes case referred to medical | | | | | 26. Place of De | nath (Check only o | | 15ELY | 'es 2□ No | | |
| or attending Physical death. Inector: After this in by the funeral di | | Hospitel: | | | | | | | | 28d. Deecribe how Injury occurred 28d. Location (Street and Number or Rural Route Number Of Town, State) | | | | |
| To the Hospital or Att within 24 hours after of To the Funerel Direct complately filled in by | and i | edicai | 29a. Certifier (Check only one) 1 Certifying Ph. 2 Medical Exam | yelclan: To the best of liner: On the basis of e end manner state | my knowledge xamination an | e, death occurred | at the tir | me, dete end plac pinlon, death occ | a, and due to the urred et the time, | ceuse(s) end ma date end place, | anner as state and due to th | ed. | | |
| To the Within To the | | ¥ | 29b. Signeture end title of certifier | Ky- | -co | | | e number | | 29d. Dete signe | d (Month, Da | | | |
| {\ | State | | 30. Neme and address of person who of THEODORE M. K. 31. Date filed (Month, Day, Year) | 3 Registrar | | 1116 | 200 | SIRI | ST BAI | sanil | Z MAG | 3/200 | | |

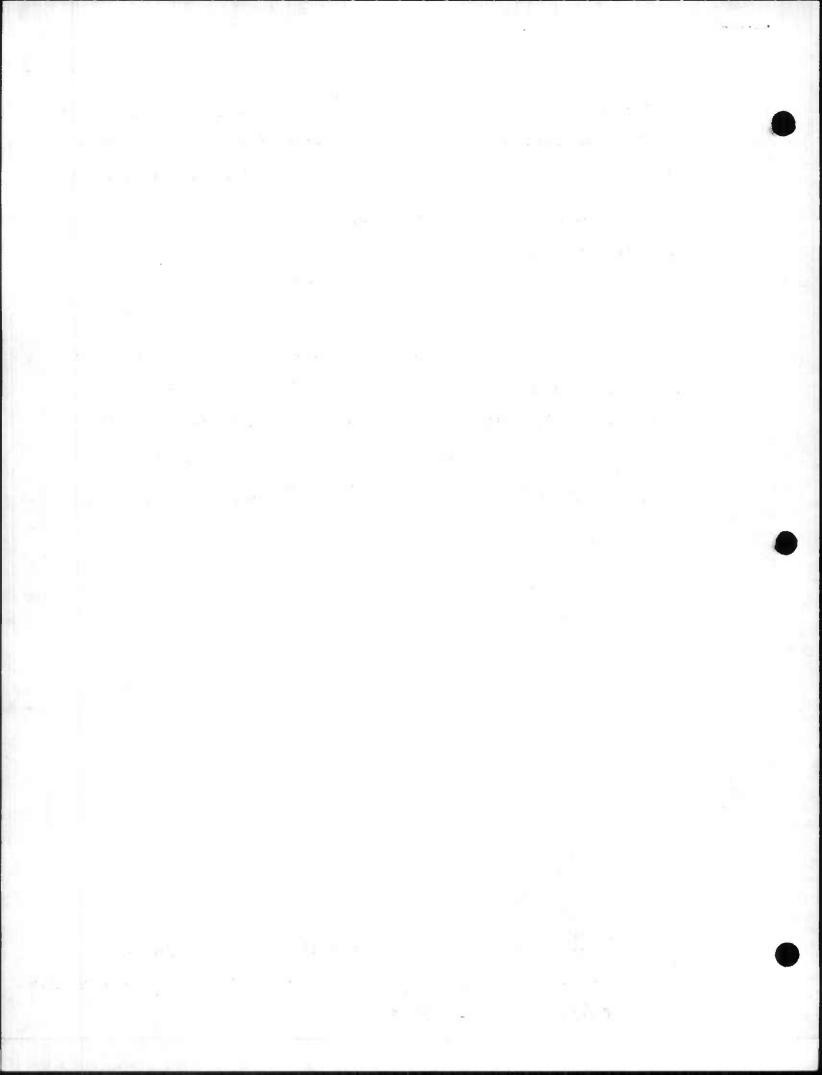


State of Maryland / Department of Health and Mental Hygiene

| _ | | | | | | | (| Certific | ate of | Death | | Reg. No. | 9 | 1 | 2/3/8 | |
|----------------|--|------------------|--|---|--|--------------------------|----------------------|-----------------------------|----------------------------------|--|-------------------------------------|--|-------------------------|------------------------|---|--|
| П | Physic | ian | Decedent's Name (Fire | | - | | | | | | 2. Date of D Month | eath Day | Ye | ar | 3. Time of Death | |
| ч | /Medi | cai | Steven F. Bezilla Sep | | | | | | | | Sept. | 4 | | 97 | 7:30 PM | |
| d | Exami | ner | | | | | | | | | | | | -1 | | |
| Н | Funerai | | 5. Social Security Number | | - | . Age (In yrs | . last birth | day) if Ur | nder 1 Yaar | If Undar 24 Hrs. | | | ne Ar | | | |
| | Director | | 113-58-9565 Usual Residence of Deca |) | X M 2□F | 22 | Yr | Mont | hs Days | Hours Min. | 8. Date of B (Month, D Apr. 1 | 8, 19 | | Country Y | ca (State or Foreign y) ork | |
| | yland | | | . County | | 10c. C | ity, Town | or Location | | | | | | 100 | d. tnside City Limits | |
| | a-fal | ctor | MD A | nne Ar | undel | | Crowr | svill | .e | | | 1 □ Yes 27 | | | | |
| | th with th | Funeral Director | 10e. Street and Numbar 1454 Fairf | ield L | oop Road | l | | 10f. | Zip Code |) | | 10g. Citiz | itizen of What Country? | | | |
| 020 | and 21215-0020 be filled within 72 hours after death with the Maryland ttal Hygiena. didner than "natural", or items 23a or 28a-f show event, the Modical Examinet must be notified as | by | 11. Marital Status 1 | | 12. Was Daced Armed Ford 1 Yes 2 if Yes, Give Year or Dat | es? No | J,S. | | | Hispanic Origin? (Si an, Mexican, Puert Specify: | pecify Yas or N o Rican, etc.) | No- 14. Race - American i Black, Whita, atc. Specify: | | | c. | |
| 5-0 | 72 hc | | 15. [(Specify on | Decedent's Ed | fucation de completad) | | 16a. D | ecedent's U | Isual Occup | eation during most of work | kina | 16b. Kir | nd of Busin | nite ess/Indu | stry | |
| 21215-0020 | within ena. than | Completed | Elementary/Secondary | | College (1-4or 5+) disabled st | | | | T use retire | d) | 9 | disa | abled | stu | dent. | |
| pu | al Hygi other | Bec | 17. Father's Neme (First, | Middle, Last) | | | | | | 18. Mother's Nan | ne (First, Middle | | | | | |
| Maryland | should be filed and Mental Hygi marked other umatic event, t | To | Lynn S. | Bezil | | | | | | Rena | F. | (Punt | t) | | | |
| Mar | 200 | | 19a. informant's Name/F | | | | 1 | | | and Number or Ru | | | | | | |
| | 1 end Health em 27 | | Lynn S. 20a. Method of Disposition | | lla, fatl | | | | | cone Ring | Dete | - | catton - City | | | |
| altimore, | Pa Int: | | 1 Buriat 2 Cre 4 Donation 5 0 | mation 3 | Removal from St | ata | | | Name of or other pla atory | | | | stead | | | |
| Ball | Departr Departr Imports any inju | | 21. Signature of Funeral | Servica Licen | Lemm | 2 | | Witz 5555 | and Address ke Fu Twin | ess of Facility Ineral Hor I Knolls I | mes, In Rd. Co | c. lumbi | ia, M | 2 | 1045 | |
| | | | 23a. Pert1. Enter the dis | ease, or compute. List only | olications that cau | used the dea th line. | th. Do no | enter the n | node of dyir | ng, such as cardiec | or respiratory | arrest, | | i f | Approximete Interval Between | |
| | Physician /Medicai Examiner | | Immediate Cause (Final disaasa or condition resulting in death) | | a. SE | ZUA | | DISO | | | | | | . / | Oyeurs | |
| | D 5 | ner | | | ME | NTA | | | | TIMAL | | | | 1 | | |
| | tificate be executed ig physician and as the burial-transit | Examiner | Sequentially tist condition if any, leading to immedi- cause. Enter Underlying | ns, | b | | | nsequenca | | 11019 | | | | 1 | 1 100 | |
| 68760, | ysiclar ysiclar | | Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): | | | | | | | | | | | | | |
| Вох 68 | | /Medicai | d. | | | | | | | | | | 0.3511-0 | | | |
| ğ | atter d for u | iciar | Dor't Other similiant | a an ellitana a | and all the state of the state of | h b. d . d . d | ulain - tu as | | | | | | | | | |
| 0.0 | by the | hys | Part tt. Other aignificant | conditiona co | antributing to deal | n out not res | suiting in tr | ie underiyin | ig cause giv | en in Part I. | | | | | he cause of death? bly 4 Unknown | |
| | gned be det | by Physician/N | DYSPHAGI | A | | | _ | | | | | 1 108 25 | J-140 3L | _ rrowa | ory 4 orikinowi | |
| Vital Records, | requires that the death ce been signed by the attendir should be detached for usa | Completed | | | | | | | | | | s an autop ormed? | sy 24 | aveil | autopsy findings abte prior to pletion of cause ath? | |
| ř | | E O | | | | | | | | | 10 | Yes 2 | X No | 10 | | |
| ia l | (P) | Be | 25. Was case referred to examiner? | medicat | | | | | | 26. Plece of Dea | th (Check only | one) | | | | |
| 5 | 1 90 | 70 | 1 ☐ Yes 2 No | | Hospitat: 1 ☐ inp | | ER/Outpo | atient 3 | DOA Oth | 4)27 Nursing H | | | | Specify) | | |
| lon | ath. r: After t | ation: | 27. Manner of Death 1 Manual 5 □ 2 □ Accident | Pending invastigation | 28a. Date of (Month, | tnjury Day Year) | 28b. Tim tnju | | 28c. injur Wor 1 🗆 | yat k? Yes 2 □ No | 28d. Describe | how Injury | y occurred | | | |
| Division of | To the Hospital or Attending Physiking A burning Laboration of the Funeral Director: After the completaly filled in by the funeral | Certification: | 3 ☐ Suicida 6 ☐ 4 ☐ Homtcide | actory, office 28f. Location (Street and Numb City or Town, Steta) | | | | r Rural F | Poute Number, | | | | | | | |
| | e Hospit 24 hour Funera Jetaly fills | edicai | 29a. Certifiar (Check only one) | Certifying Phy Medical Exam | stcian: To the be itner: On the basi and manne | s of examine | wledge, detion and/o | eath occurr r investiget | ed at the tin ion, in my o | ne, date and place, pinion, deeth occur | and due to the red at the time, | cause(s) , date and | and manna ptace, and | r as stat due to th | ed. ne cause(s) | |
| | To the withing To the complete | × | 29b. Signature and title of | f certifier | | | | | 29c. Licans | | | 29d. Date | signed (M | onth, De | iy, Year) | |
| | | | Declan MD D3 | | | | | | | D38958 9/5/97 | | | | | | |
| , | X | | 30. Neme and address of | | | of death (Iter | n 23a) (Ty | | | | | - / - | 1 | - | | |
| | | | DALJEET | | NGH S | DHU | M | D 10 | 113 AA | INAMILIS | ROAD | #10 | 6 001 | ENT | ON MD 211C | |
| | Sta Registr | | 31. Dete fited (Month, De) | y, Yeer) 1997 | Freight. | avidson | - Randi | M. | | | | | | | | |

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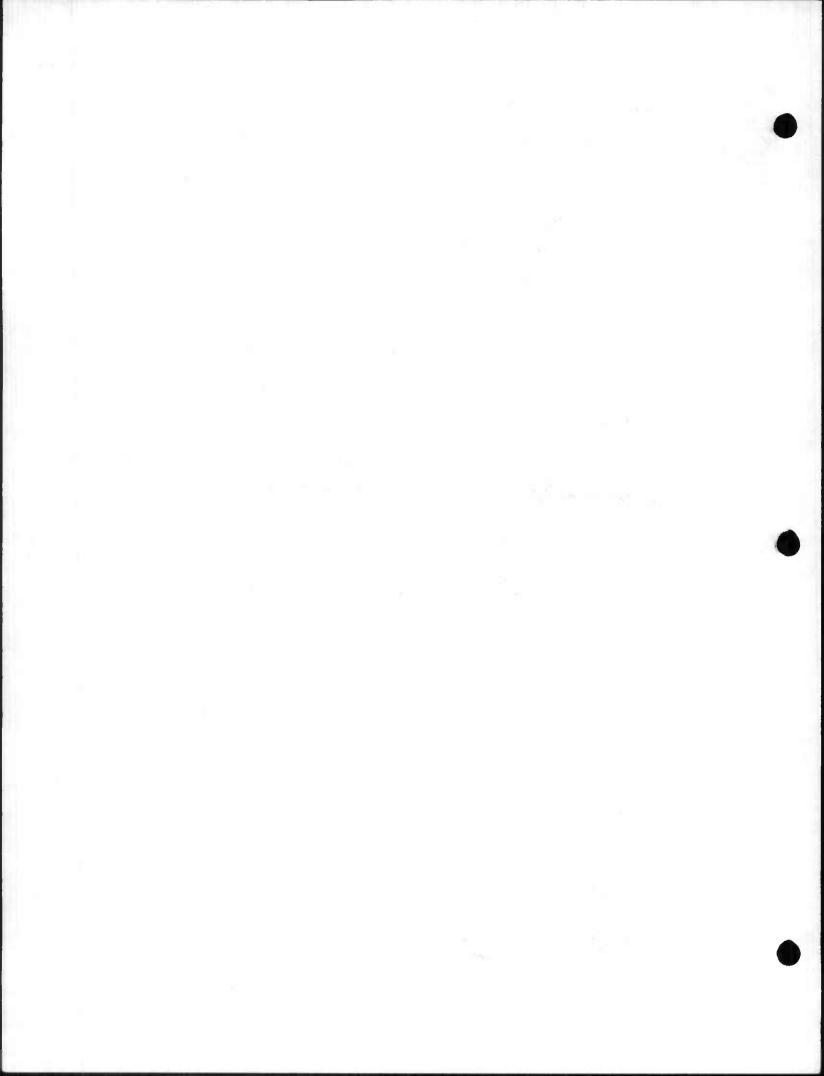
SEP 1 0 1997



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene OT

| | Physici | | Decedant's Nama (First, Middla, Last) RUSSELL Francis | Covaheu | | tificate of | | | Reg. No. | 3. Tima of Death 11:30 AM | | | | |
|---|--|------------------|---|---|--|--|--|---------------------------------------|------------------------------------|--|--|--|--|--|
| | /Medic Examir | | 4a. Fecility Name (If not institution, giva street 9915 Gunforge Roa | et and number) | | 4b. City, Town, or Perry | Location of Death | 4c. County | /// | | | | | |
| | unerai irector | | 5. Social Security Number 6. Sax 12 M | 7. Age (In yrs. | last birthday) Yrs. | If Undar 1 Year Months Days | tf Under 24 Hrs. | | | 9. Birthplace (State or Foraign Country) MaryLand | | | | |
| land | M H | | Usual Rasidance of Decedant 10a. Stata 10b. County | | | 10d. Inside City Limits | | | | | | | | |
| Mary | 19 | ctor | Maryland Baltimore | 2 | | Perry | Hall | | | 1 ☐ Yas 2 No | | | | |
| vith th | or 28 | Funeral Director | 10e. Straat and Number | | | 10f. Zip Code | | | 10g. Citizen of What Country? | | | | | |
| eath v | 78 23e | eral | 9915 Gunforge Road | Vas Decedent Ever in U | S 13 W | 21 i | | pecify Vas or No | | S.A. e - Amaricen Indian, | | | | |
| Naryland 21215-0020 2 should be filed within 72 hours efter death with the Manyland | Examination | by | 1 Nevar Married 2 Married | 1. Yas 2 □ No | | | s Decedant of Hispanic Origin? (Specify Yas or Nas, specify Cuban, Maxicen, Puarto Rican, etc.) Yes 2 No Spacify: | | | White | | | | |
| 2-0 72 ho | natur | eted | 15. Dacedant's Education (Specify only highast grada con | n mplated) | 16a. Dacedant's Usuel Occupa (Giva kind of work dona d | | | rking | 16b. Kind of Bu | usinass/industry | | | | |
| Maryland 21215-0020 id 2 should be filed within 72 hours ef | than " | Completed | | Collaga (1-4or 5+) | 'iita. DO NOT usa retired) Ceramic Tile Contrac | | | | Self-E | mployed | | | | |
| Di filed | other other | Be Co | 17. Fether's Nama (First, Middla, Last) | | 00000 | | | ne (First, Middle, | 0 | , , | | | | |
| Vial be | rked atic ev | To B | Michael Joseph Co | vahey | | - 4 | Elsie | Lohr | | 249 | | | | |
| War 12 sho | la mara | | 19a. Informant's Name/Ralationship (Type, I Anne Covahey (u | Print) Vife) | | | tand Number or Rue Road. | | | Stete, Zip Code) 21128 | | | | |
| Healt | other | | 20e. Mathod of Disposition | • | | ition (Nema of etory or other pla | | Data | | City or Town, Stata | | | | |
| Pages | permit. Pages 1 and 2 should be filed within 72 hours efter death with the Manylan Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | | W Burial 2 ☐ Cramation 3 ☐ Remo | | | | | 9/8/97 | | re, Maryland | | | | |
| Baltimore, permit. Pages 1 ar | Importa any inju | | 21. Signature of Funaral Sarvice Licenses 22. Name and Addrass of Fecility Schimunek Funeral Homes, Inc. | | | | | | | | | | | |
| | | | 23a. Part1. Entar tha disaasa, or complication | ons that causad tha daat | | | | | | 21236 Approximeta | | | | |
| /M | vsician ledical aminer | | shock, or haart failura. List only one ca | | tary | Avre | 8+ | | | Intervel Batwaan Onset end Deeth | | | | |
| | 50 | Examiner | b. — | Na Sue | r as a consequence as a | ence of): ance of): | ung c | lance | | Smo | | | | |
| ox oo/ou, | nding physician and use as the burial-transit | edical | Cause (Disaase or Injury that initieted evants rasulting in death) Last Dua to (or es e consequence of): | | | | | | | | | | | |
| S, T.O. DOX | igned by the attendin be detached for use | by Physician/M | Pert II. Other significant conditions contribu | ting to death but not ras | ulting In the un | derlying causa g | van in Part I. | 23b. Dtd | tobacco use con | ntribute to the cause of death? | | | | |
| | s been s 2 should | Completed I | | | | | | 24a. Was perfo | an autopsy ormed? | 24b. Were autopsy findings available prior to completion of cause of daath? | | | | |
| <u> </u> | cartificate has irector, page 2 | | | | | | | 10 | Yas 21 No | 1 □ Yas 2010 | | | | |
| VIL | is cartificate ha director, page | o Be | 25. Wes case refarrad to madicel axaminer? 1 Yes 2 No Hospi | tel: 1 ☐ Inpatiant 2 ☐ | ER/Outpatient | 20 DOA OI | har- | ath (Check only o | | (0%) | | | | |
| Attending Physician: | Viter this uneral di | on: To | 27. Manner of Death 12 Natural 5 ☐ Pending | Ba. Dete of Injury (Month, Dey Yaer) | 28b. Tima of Injury | 28c. Inju | ry at | 28d. Describe | how injury occur | | | | | |
| - X - | Director: After | Certification: | 2 Accidant investigation 3 Suicida 6 Could not be 4 Homicide determined | Ba. Place of Injury - At he building, atc. (Specification) | oma, farm, stre | |]Yas 2□No | 28f. Location (: City or Tox | | per or Rural Routa Number, | | | | |
| To the Hospital of within 24 hours at | To the Funeral Director: After the completely filled in by the funeral | edical Ce | 29a. Certifier (Check only one) Certifying Phyalcial 2 Medical Examiner: | n: To the best of my kno On tha basis of axamina and mannar statad. | wledga, daath tion end/or inva | occurred at the t estigetion, in my | me, dete and place opinion, daath occu | , and dua to tha rred at tha tima, | causa(s) and ma dete end pleca, | annar as stated. end dua to tha causa(s) | | | | |
| Toth | Som T | M | 29b. Signapore and the of artifler | m | | | se number 2-3 8 2 | | 29d. Date signer | d (Mogth, Dey, Year) | | | | |
| , | J. (| | 30. Nama and address of person why comple Dr. Albert Deloske. 31. Dete filed (1977) Ddy, nat 1007 | oted causa of daath (Itam | 23a) (Type, P | rint) ve., Tol | uson, MD | 21204 | , | | | | | |

Registrar



State of Maryland / Department of Health and Mental Hygiene 97 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Sept. **Physician** Duffie Alice Crouse /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner House of Bel Air Bel Air Harford 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Data of Birth
Months Davs Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (Stata or Foraign Country) **Funeral** 1□M 2☑F 204-28-2904 Yrs 84 Director Sept. 19, 1912 West Virginia Usuai Rasidance of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Maryland Harford 410 E. MacPhail Road, Bel Air, Md. 1 Nas 2 No Director 7 is marked other than "natural", or items 23s or 28s-4 traumetic event, the Medical Examinat must be notified 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 410 E. Mac Phail Road 21014 USA 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Biack, Whita, atc. 1 ☐ Nevar Married 2 ☐ Married 1 Yas 2 No If Yas, Giva Yaar or Datas: Baltimore, Maryland 21215-0020 1 ☐ Yas 2√ No Specify: þ Specify: White 3√3√Widowed 4 □ Divorcad 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Clothing Eiamantary/Secondary (0-12) Coliaga (1-4or 5+) Seamstress Manufacturing 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Surnama) 2 should be fit h and Mental H is marked off William Kenny Good Maudie Ann Morrison 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If then 27 is in any injury or other traun once. 2632 Harkins Road, White Hall, Md. 21161

Obsposition (Nama of Date 20c. Location - City or Town, Stata Mary Lowe/Daughter 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 9/7/97 XX Buriai 2 Cramation 3 Ramoval from Stata White Hall, Md. 4 ☐ Donation 5 ☐ Othar (Specify) Norrisville Cemetery 22. Nama and Addrass of Facility J. J. Hartenstein Mortuary, Inc. 19 S. Main St., Stewartstown, Pa. 17363 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, only obscurate on each line. Physician Sepsis /Medical Immediata Cause (Final 6 days disaasa or condition rasulting in daath) Examiner Dua to (or as a consequence of) Examiner physician and the budal-transit Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Causa (Disaase or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of) Physician/Medical Dua to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by I Alzheimers Demantin 1 Yes 2 No 3 Probably 4 Unknown ģ 24b. Wara autopsy findings available prior to completion of cause of daath? Completed 24a. Was an autopsy performed? 1 ☐ Yas 2 No 1 Yes 2 No Division of Vital 25. Was casa rafarred to medicai 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannar of Deeth 28b. Tima of 28d. Dascribe how injury occurred Certification: 1 Natural 2 Accident 5 Panding death. 1 ☐ Yas 2 ☐ No invastigation i or Attend after death Director: To the Hospital or Atter within 24 hours after dea To the Funeral Director completely filled in by th 6 Could not be datarmined 28f. Location (Streat and Number or Rural Routa Number, City or Town, Steta) 3 ☐ Suicida 28a. Place of injury - At home, ferm, street, factory, office building, atc. (Specify) 4 - Homicide 15 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Description Medical Examiner: On the basis of exeminetion and/or invastigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. 29e. Certifian 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) September, 4, 1997 D34652 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Bel Air Mary land 21014 Scott Huswell North Ave

Registrar

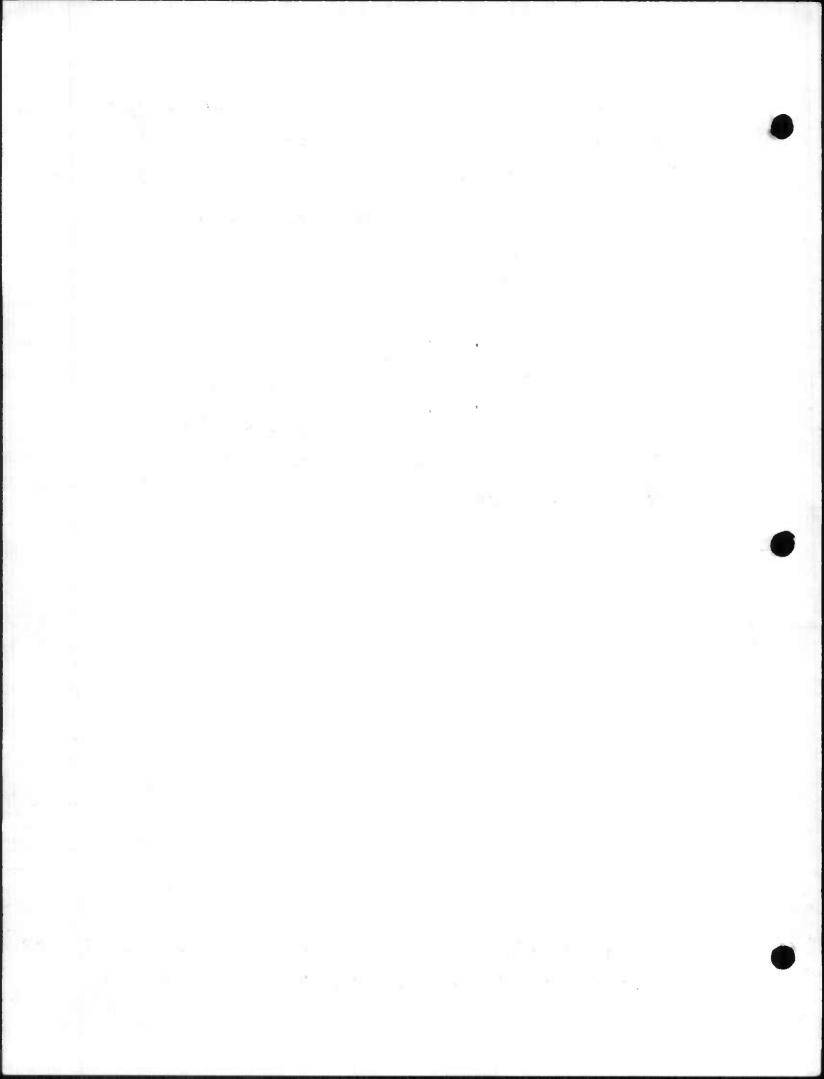
State

31. Data filed (Month, Day, Year)

32. Ragistrar's Signatura

Julia Davidson Randoll

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Item 1 Per PHY Film G751 9-25-97 rja Certificate of Death

requires that the death certificate be executed bunial-transit and Box 68760. physician the attending ed by the g P.O. signed by t d be detach Records, been s

1. Decedent's Name (First Middle Last) 2. Date of Death Day **Physician** Month 4, SEPT. CONNELLY CHARLES 1997 1:40 FM Sr. /Medicai 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Saint Joseph Medical Center Towson If Under 1 Year | if Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) **Funeral** Deys 1 M 2□ F Months Hours 215-12-9184 75 Yrs. 3, Director 1922 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumstic syant, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Md. Baltimore Dundalk 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? with 5 7110 Sollers Point Rd. itsms 23a 21222 USA death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Black White etc. filed within 72 hours after 1 Never Married 2 Married ty Yes 2 No If Yes, Give Year or Dates: Maryland 21215-0020 ò 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self Employed 12 yrs. Funeral 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 12 should be fill h and Mental H Is marked off Be J. Gordon Connelly Sr. Cecelia V. Fialkowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Heaith a Important: If Item 27 is any Injury or other the Anna Connelly wife 7110 Sollers Point Rd. Dundalk Md. 21222 Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Oak Lawn Cem. 9-8 Baltimore 22. Name and Address of Facility Connelly Funeral Home Of Dundalk Hurh 7110 Sollers Point Rd. 21222 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical ADULT RESPIRATORY DISTRESS SYNDROME 10 DAYS Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner 10 DAYS MULTIPLE ORGAN FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Lest Due to (or as a consequence of): CANCER OF THE PANCREAS Physician/Medical Due to (or as a consequence of): STATUS POST WHIPPLE RESECTION 13 DAYS Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown b 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 T Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Division of Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending Parter death. Natural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) 2 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 29a. Certifier 🗹 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Dey, Year) oliento D 02547 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERTO FERRER, M. D., 7600 OSLER DR., TOWSON, MARYLAND Culias Books sersion and De State

Registrar

s v 11-2 v 1 31

State of Maryland / Department of Health and Mental Hygiene

Physician Examiner

Funeral

Director the Maryland 28a-f show must be notified at ò Nerns 23a ò

"naturs!". the Medical than Hygiene. other 12 should be fi h end Mental H 1s marked ou permit. Pages 1 and 2.
Department of Heelth el
Important: if Item 27 is
any Injury or other trau

Baltimore, Maryland 21215-0020

Physician

certificate be executed and physician ettending I for usa as signed by the equires

Box 68760,

P.O.

Records,

Vital

of

Division

this Aftar Attending death. To the Hospital or Attendition within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

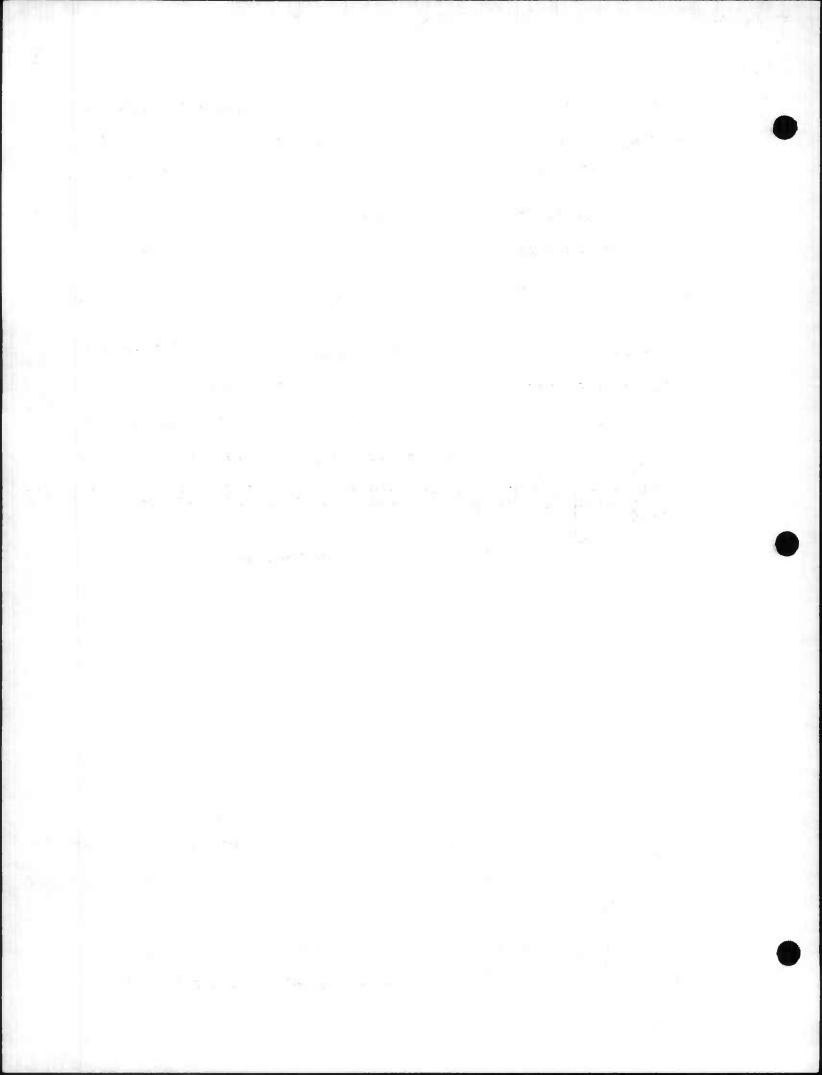
State Registrar

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Day DALE CONNER SEPTEMBER 04,1997 9:31 P 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth 3623 MILFORD AVE. BALTIMORE If Under 1 Year 8. Date of Birth (Month, Day, Year) 12/17/1960 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthpiece (State or Foreign Days Houre 1 M 2 □ F 216-88-2530 36 Yrs. Carolina Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d, Inside City Limite MD BALTIMORE RANDALLSTOWN Director 1 Yes 2 XNo 10e. Street end Number 10f. Zlp Code 10g, Citizen of What Country? 4810 OAKLAND PARK ROAD 21133 U.S.A. Funeral 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Never Married 2 ☑ Married ty Yes 2 No If Yes, Give Yeer or Dates: 1 Yes 2 No Specify. Black þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Contractor Entrepreneur 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) James C. Conner Kay Dorsey 19e. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 1 3 3 Kay Conner 4810 Oakland Park Road, Randallstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Locetion - City or Town, State 1 ☐ Burie! 2 X Cremation 3 ☐ Removal from State Metro Crematory 9/8 Baltimore, MD tion 5 Other (Specify) of Funeral Service Lice 22. Name and Address of Fecility LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE. BALTO. 21207 or complications that can high the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Approximeta Interval Between Immediate Ceuse (Final CONTISCT GUISHOT WOUND OFFICED disease or condition resulting in death) Due to (or as e consequence of) Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown p Be Completed 24a. Was en eutopsy performed? 24b. Were eutopsy findings evailable prior to completion of cause of death? 1 Yes TEYes 2 No 25. Was cese referred to medical 26. Place of Death (Check only one) XXYes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 1 Naturel 5 Pending Surspect SHOT SELF. 1 Yes 2 10 No 1730YM 9-4-97 Investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide RESIDENCE 3623 HILFORD DUE BATHORE 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as steled.

**Medical Exeminar: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and menner stated. edical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME SEPTEMBER 05, 1997 30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print) MARIDANO B. KORFU 111 Penn Street, Baltimore, Maryland 21201

31. Dete filed (Month, Day, Year) SEP 1 0 1997

32. Registrar's Signature relia Arvidson

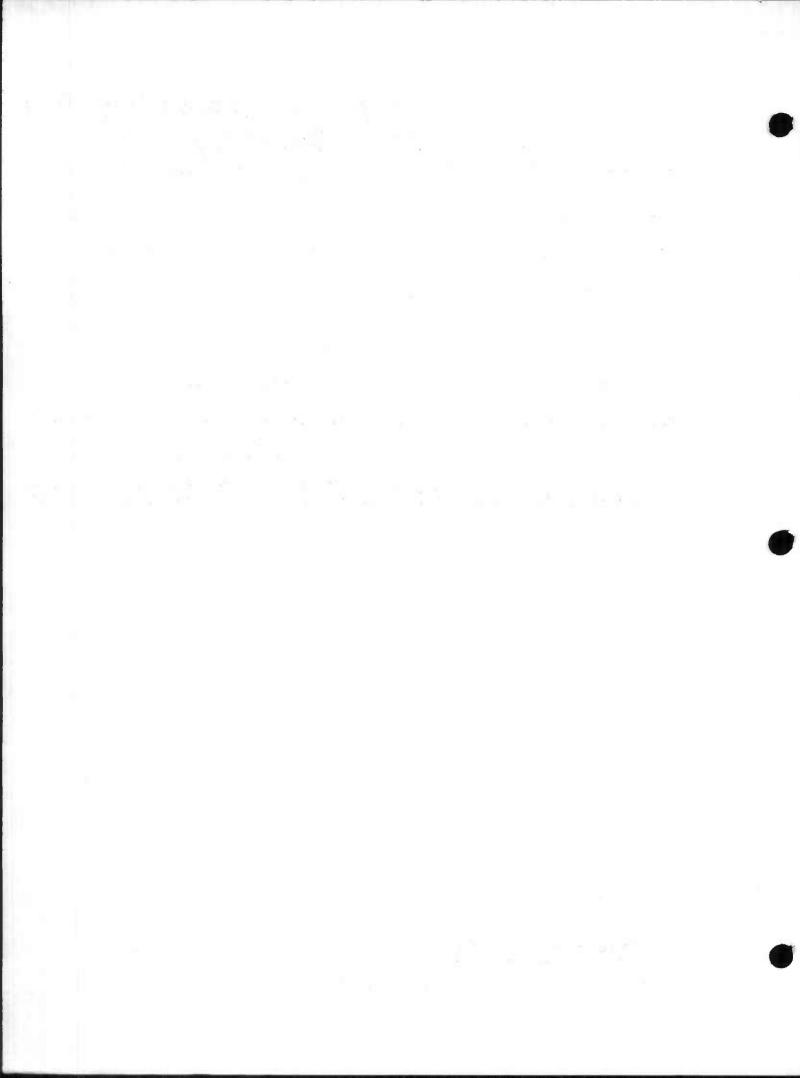


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death **Physician** WILLIE /Medical 4a. Fecliity Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner BALTMORE ARYLAND GENERAL if Under 1 Year 5. Sociei Security Number if Under 24 Hrs. 8. Dete of Birth 9 (Mogth Day Year) 9 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Carolina **Funeral** Months Deys Hours 243-24-8315 12 M 2□ F 77 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural; or items 23a or 28a-f show ury or other traumetic event, the Medical Examiner must be notified at 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE MD N/A 1 ☑ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 ELLICOTT DRIVE U.S.A. 21216 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No 1 0 / 4 2 If Yes, Give Year or Dates: 6 / 4 3 1 ☐ Never Merried 2 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 18b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Auto Parts Truck Driver 6th 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jim Crosby Mary Jane Crosby 2 19a. Informant'a Name/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Crosby 1000 Ellicott Drive, Baltimore, MD 21216 20b. Placa of Disposition (Name of 20a. Method of Disposition 9/12 Date 20c. Location - City or Town, State cemetary, crematory or other place) ₩ Burlai 2 Cremetion 3 Removal from State permit. Page Department of Important: If any Injury or once. Garrison Forest Vet. Cem. Owings Mills, MD4 Dopation 5 Dother (Specify) 21. Signature of Funerel Service Licenses 22. Name and Address of Facility LEROY O. DYETT & SON FUNERAL HOME, 4600 LIBERTY HEIGHTS AVE., BALTO. 21207 or complications that caused to deeth. Do not enter the mode of dying, auch as cardiac or respiratory arrest, only one cause on each line. Approximsta interval Between Onset and Death Physician Congestion recurren /Medical and Immediate Cause (Final disease or condition resulting in death) Examiner 20 condary to mucus as a consaquanca of): Examiner physician and the bunal-transit Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last of Vital Records, P.O. Box 68760. Arteriolar Nephrosclerosis CVA Physician/Medical Due to (or as a consequence of) 88 980 signed by the a d be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Wara sutopsy findings available prior to completion of cause of death? 24a. Was sn autopsy performed? Completed peed page 2 s 1 Yes LEYes 2 No certificate 2 No ding Physician: director. 25. Was case referred to medical Be 28. Place of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient 2 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day Year) uneral 27. Manner of Death Certification: 28b. Time of 28c. injury et Work? 28d. Describe how injury occurred Altor 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, ferm, street, factory, offica building, etc. (Specify) 4 Homicide edicai 29a, Certifier tertifying Physicisn: To the best of my knowledge, daath occurred at tha tima, data and place, and dua to tha cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and menner stated. To the within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and addr 0 .32. Aregistrar's Signature State

DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene Q7 27381

| | | | | | | Certificate d | of Death | F | eg. No. | 1 41 | 1304 |
|---------------------|---|----------------|---|--|---------------------------------|--|--|---|---|-------------------------------------|---------------------------|
| | Dharata | | 1. Decedent's Nema (First, Middle, La | * | | | | 2. Dete of Dee | th | | Time of Death |
| | Physic /Medi | | PAN S | CH | 0 | | | SEPTEMB | ER"6, | 1997 | 1:35 PM |
| | Exami | | 4a. Fecility Neme (If not institution, given Saint Joseph | rastreet end number) Medical | Cente | r | | Location of Deeth SON | 4c. County | of Deeth Baltin | nore |
| | Funerai Director | | 214-04-0735 | Sex 7. Aga 1□ M 2점 F | 72 | | aar If Undar 24 Hrs bys Hours Min | | Year) 1925 | Country) | State or Foreign Japan |
| | pue ** | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Town | or Location | | | | 10d. fn | side City Limits |
| | death with the Marylend ms 23a or 28a-f show | tor | Md. N/A | | Bal | timore | | | | 1₹ | Yas 2 No |
| | or 284 | Director | 10e. Street and Number | | | 10f. Zip Coo | le | 1 | 0g. Citizen of V | Whet Country? | |
| | 23a c | rai | 1662 Roundhill Rd | l. | | 23 | 1218 | | | rea | |
| Maryland 21215-0020 | d 2 should be filed within 72 hours effer death with the Marylen th and Mental Hygiene. 7 is marked other than "naturel", or flems 23a or 28a-f show treumstic event, the Modell Evanting must be notified. | by Funerai | 11. Marital Stetus 1 □ Nevar Marriad 2 □ Married 3 □ Widowed 4 □ Noivorced | 12. Wes Decedent E Armed Forces? 1 ☐ Yas 2 ☑ N If Yes, Give Yeer or Dates: | | If Yes, specify Cuban, Mexican, Puerto | | | pecify Yes or No- o Rican, etc.) 14. Race - America Bleck, White, e Specify: Kore | | |
| 5-0 | 72 ho | eted | 15. Decedent's En | | 16e. | Decedent's Usual Oc | cupetion ona during most of wo | nkina | | usiness/industry | |
| 121 | vithin ne. hen " | Completed | Elementery/Secondary (0-12) | College (1-4or 5 | | life. DO NOT use re | tired) | WOIKHIG | | | |
| D | filed with Hygiene. ther than | | 9 17. Fether's Neme (First, Middle, Last | | H | ome Maker | 18 Mother's Na | m <i>e (First, Middle,</i> | Own Hol | | |
| an | 2 should be filed v and Mental Hygie is merked other t eumatic event, th | To Be | Eui Won | Cho | | | Soon | Duk | | ho | |
| ary | should and Men marke umatic | _ | 19e. Informent's Name/Reletionship (| Type, Print) | 19b | . Meiting Address (Sti | | | | |)) |
| | | | Mrs. Kil Cham Fis | ke/daughte | r 16 | 62 Roundh | ill Rd. Ba | ltimore, | Md. 21 | 218 | |
| altimore, | Pages 1 end nent of Healt int: if Item 27 iry or other i | | 20a. Method of Disposition 1 Burial 2 XCremetion 3 | Ramoval from State | 20b. Plece of cemeter | Disposition (Name or y, crematory or other | f place) | Dete | 20c. Location - | City or Town, S | tate |
| ti m | tant: | | 4 ☐ Donetion 5 ☐ Other (Specif | fy) | Hillto | p Service | | 9/10/97 | Tows | on, Md. | |
| Ba | permit. Pages 1 en Depertment of Heal Important: if Item 2 any Injury or other once. | | 21. Signature of Funeral Service Licer | f. Sa | lis | | dress of Fecility son Funera Rd. Tows | | | | |
| | 17.00 | | 23a. Pert1. Enter the bisees of com shock, or heart feilure. List only | pications that paused | the deeth. Do r | | | | | Appr | roximate vet Between |
| | Physician | | | | | CEREBRO | | | | Onse | B DAYS |
| | /Medicai Examiner | | Immediate Ceuse (Finel disease or condition resulting in deeth) | e | MINOIC | CENEDIO | VHOCULHI | MUUIDE | 141 | | DHIS |
| | 0.0 | ē | | WITH | Due to (or es e o | consequence of): E SHIFT | | | | | |
| | id ensit | Examiner | Sequentially list conditions, | b | | consequence of): | | | | | |
| oʻ | an an | Ex | if eny, laeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury | | | | | | | | |
| 68760, | certificate be executed rding physician and use es the buriel-trensit | edicai | thet initiated events rasulting in death) Lest | C | Dua to (or as a c | onsequence of): | - | | | | |
| × | = 00 | 2 | | d | | | | | | | |
| 80 | atter | Physician/ | | | | | | | | | |
| o | 0 0 % | hysi | Pert II. Other significent conditions of | ontributing to death bu | it not resulting in | the underlying couse | given in Pert I. | | | | 4% Unknown |
| ď | es that igned b | by P | | | | | | 101 | 95 ZU NO | 3 Probably | 405 Offictions |
| Records, | mquires that the | pleted | | | | | | 24e. Wes e perfor | | eveileble | ion of ceuse |
| | IR | E | | | | | | 1 🗆 Y | es 2 No | 1 ☐ Yes | 2 X No |
| Vital | N | Bed | 25. Wes casa referred to medicel exeminer? | | | | 26. Plece of De | eth (Check only or | ne) | | |
| 5 | Physics rthis de srai dire | 0 | 1 ☐ Yes 2X No | Hospital: 1 Inpatier | | | | Home 5 ☐ Resid | | | |
| uc | After funer | ion: | 27. Manner of Deeth 1 Naturet 5 Pending 2 Accident Investigation | 28e. Dete of Injur (Month, Day | Year) 28b. T | | njury et Work? 1 □ Yes 2 □ No | 28d. Describe h | ow Injury occur | ed | |
| Division of | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | Certification: | 2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined | On Discontinu | ry - At home, fa . (Specify) | rm, street, factory, off | | 28f. Location (S City or Tow | treet end Numb n, Steta) | er or Rurel Rou | te Number, |
| | To the Hospital or within 24 hours after To the Funeral Dir. completely filled in | edicai (| 29e. Certifier (Check only one) | nysician: To the best of niner: On the basis of end menner stat | examinetion and | , deeth occurred et the | e time, date end plec ny opinion, deeth occ | e, end due to the curred et the time, c | euse(s) end me lete and plece, | nner as steted. and due to the c | cause(s) |
| | To the Within 2 To the comple | Me | 29b. Signeture end title of pertifier | | | | ense number | 2 | 9d. Dete signa | d (Month, Day | Year) |
| | | | > exting of | mehle | , m.D | D | 41410 | | Sylan | ibu Th | 1997 |
| | 10 | | 30. Name and a person who JOGINDER P. M | completed ceuse of de | eeth (Item 23e) (| Type, Print) | MEDICOL | CENTER | TOLICON | MT | <i>I</i> - |
| | 10 | | 31. DS 10 (North 4997ar) | 10. 20. | Auster France | | MEDICAL | CENTER | IUWBUN | I, MD. | |
| | Sta | ite | OHIL OF O JOSIE | A . an cole lit | Mobile ada | No. of B | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month CARR Dep 4b. City, Jewn, or Location of Death Fecility Neme (If not institution, give streat and number) 4c. County of Deetl BAITimore 705pic 7. Age (n yrs. last birthday) chie 8. Data of Birth (Month, Day, If Under 1 Yaar If Undar 24 Hrs 9. Birthplece (State or Foreign Country) 5. Sociel Security Number Months Deys Min. Hours 5-36-6820 1 ☐ M 2 🗓 F Yrs Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No more 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hisperlic Orlgin? (Specify Yas or No If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yas 2 No tf Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced 16e. Decedent's Usuel Occupation
(Give kind of work done during most of working
life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, 19e. Informent's Name/Reletionship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) emd21216 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Ramovel from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funaral Service Liceoses 11. Enter the disease, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or respiretory errest, or heart feilighe. List only one cause on each line. Approximete Intervei Between Onsat and Deeth Immediete Ceuse (Finel diseesa or condition resulting in death) CARCINOMA OF DESOPHACUS 4-MONTHS Due to (or es e consequence of) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of) Due to (or as a consequence of): 23b. Dtd tobacco use contribute to the cause of death? 3 Probably 4 Tunknown 1 ☐ Yes 2 ☐ No DIABETES 24b. Were autopsy findings available prior to completion of causa of deeth? 24a. Wes en autopsy performed? 1 Yes 1 ☐ Yas 2 ☐ No 26. Place of Deeth (Check only one)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

28a-f show

ò

"natural", or items 23a

permit. Pages 1 end 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or iten any injury or other treumetic event. Its

Baltimore, Maryland 21215-0020

Directo

Funeral

by

Completed

other treumstic event, the Madical Examiner name by notified at

Physician/Medical Examiner

physician and as the bunal-transit 950 signed by the a page 2 s After

P.O. Box 68760, Division of Vital Records, Hospital or Attanding Physician: after death.

Director: Aft
d in by the fun To the Hospital or within 24 hours aft To the Funeral Di completely filled in

State Registrar

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ď Completed 25. Wes case referred to medical exeminer?
1 ☐ Yes 2 ☑ No Be Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSICE Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 28d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 18 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. Medical 29a. Certifier 2 Medical Examiner: On the basis of examinetion end/or Investigation, In my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated.

29c. License number

29d. Date signed (Month, Day, Year)

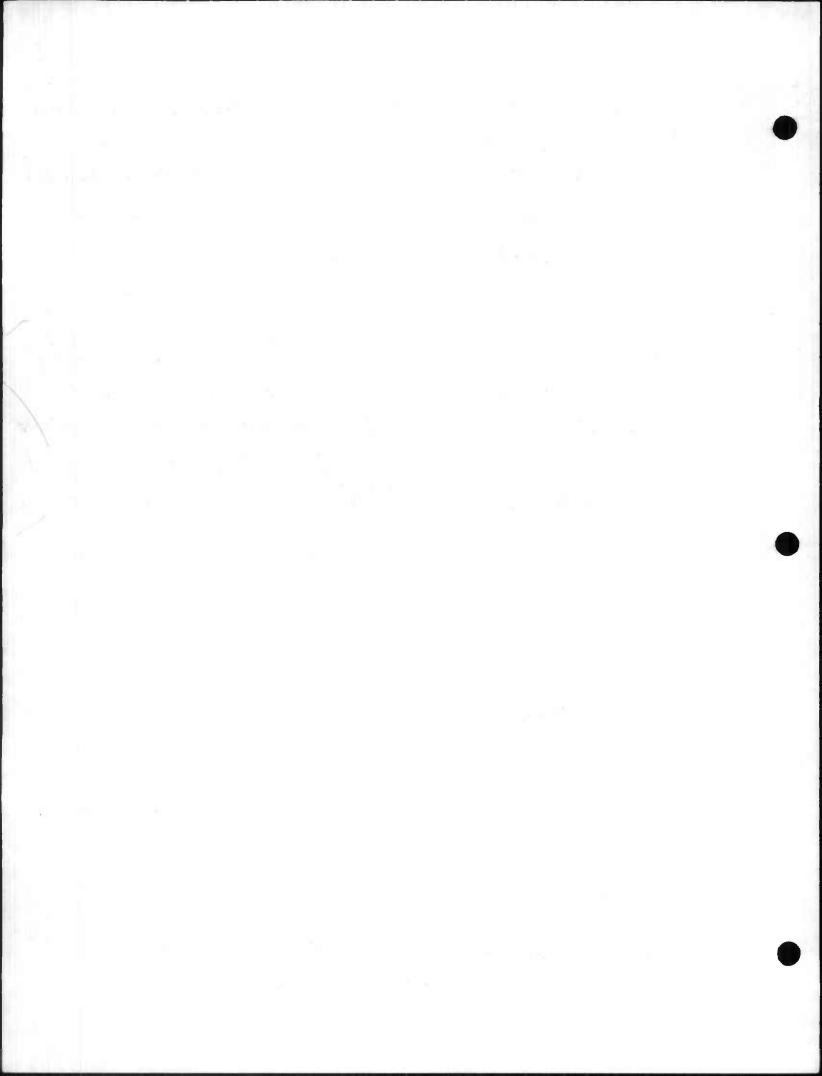
MACGIBBON MO 10/97

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

101 WREADST. MARGIBBON BALTMANE 21201

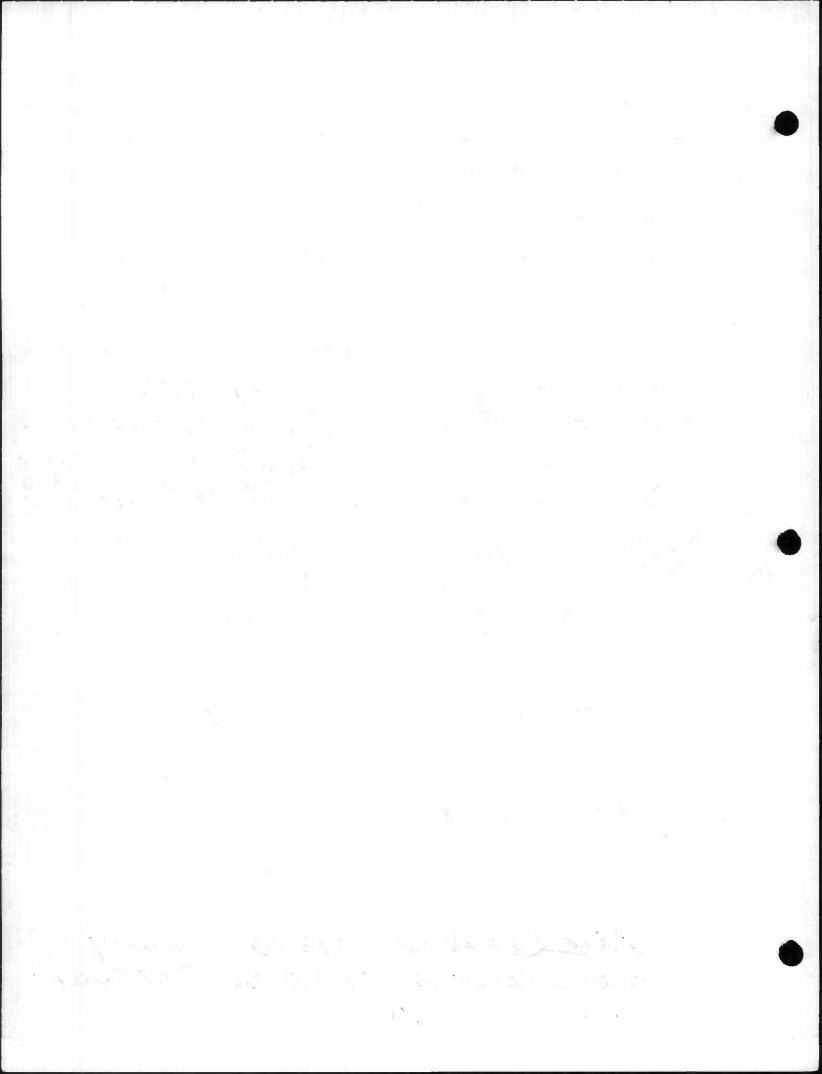
29b. Signeture end title of certifier

12 Registrar's Signeture July Davidson-Randall



State of Maryland / Department of Health and Mental Hygiene

| | | | | Certificate of | | R | g. No. | 27386 |
|-------------------|---|----------------|--|--|--|---|---------------------------------------|---|
| | Physic | ian | 1. Decedent's Name (First, Middle, Last) Lillie G. CAMEZOI | (| | 2. Date of Deat Month | - | 3. Time of Death |
| | /Medi Examir | | 4a. Facility Name (If not institution, give street end number) | V | 4b. City, Town, or | | 4c. County of | 97 10:09AM |
| L | 100 | Ш | 100N SECOURS HOSPITAL | | BALTIN | | N | A |
| | Funeral Director | | 5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. lest birth 43-48-0/85 Y Usual Residence of Decedent | Months Days | | | | Birthplace (State or Foreign Country) VORTH CAROLINA |
| | dand wo | | 10a. State 10b. County / 10c. City, Town | or Location | | | | 10d. Inside City Limits |
| | Ba-f sh | Director | MD NA BALTI | MORE | | | | 10 Yes 2□No |
| | death with the Maryland rms 23a or 28a-f show r nsuit be notified at | al Dire | 10e. Street and Number 1827 ARUNAH AVE. | 10f. Zip Code | 1217 | 10 | og. Citizen of Who | |
| 5-0020 | or its | by Funeral | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorcad 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 To No If Yes, Give Year or Dates: | 13. Was Decedent of If Yes, specify Cu | | Specify Yes or No- to Ricen, etc.) | | American Indian, White, etc. |
| | "natur | Completed | 15. Decedent's Education 16a. (Specify only highest grede completed) | Decedent's Usual Occu Give kind of work don | e during most of wo | rking | 16b. Kind of Busin | ness/industry |
| 2121 | iene. | ошр | Elementery/Secondary (0-12) College (1-4or 5+) | life. DO NOT use retir | triin) | | Food | Service |
| | be filed tal Hygi d other event, | 3e C | 17. Father's Name (First, Middle, Last) | ~ · · · · · | 18. Mother's Na | me (First, Middle, N | | |
| Maryland | should b | To Be | Glenne Drawly | | Cer | my (| rtis | |
| Ma | nd 2 sh alth and 27 is rr r traum | | 19a. Informant's Name/Relationship (Type, Print) | Mailing Address (Street | et end Number or Ri | ural Route Number, | City or Town, Ste | ete, Zip Code) |
| re, | of Heal | | | Disposition (Name of cremetory or other pl | wan | Dayle / 2 | Oc. Location - Cit | y or Town, State |
| E | Page nent o nnt: If ury or | | 1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify) | Tur Memo | esia O Ansi | 19/8/97 | 3altin | core Marilas |
| Baltimore | Department of moortants of moortants of moortants of any Injury or once. | | 21. Signature of Funeral Service Licensee | 22. Name and Addi | ress of Facility | it. Phu | Plips Fu | noral Home la |
| | 00540 | Ш | Novetha Hector CFSP | 1721-27 | Nmon | ROE Str | ect Bal | |
| | Dhysisian | | 23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. | t enter the mode of dy | ring, such as cardia | or respiretory arre | est, | Approximate Interval Between Onset and Death |
| } | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | 0 440 | cardi | al. 17 | tore | ton |
| | Examiner | J. | resulting in dealth) | insequence of | Ç | | 0 | |
| | nsit | Examiner | b. H49 | Dorson | 100 | | | 8- |
| Ć, | icate be executed physician and s the buriel-transit | Exar | Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or Injury | nsequenca of): | Room | torse | GAGG | |
| 68760, | ite be iysicia he bur | edicai | Cause (Disease or Injury that intitlated events resulting in death) Last Due to (or as a control of the control | nsequence of | 1000 | 9 310 | | |
| 39 x | ertifica ling ph | - | d. | | | | | |
| Вох | attend for us | clan | | | | | | i |
| P.O. | es that the death cer igned by the attendir be detached for use | Physician/ | Part II. Other significant conditions contributing to death but not resulting in t | he underlying ceuse g | iven in Part I. | | | bute to the cause of death? |
| S, P | gned be det | by P | Heavy Smoke | 2 | | 110(Ye | s 2□ No 3 | □ Probably 4 □ Unknown |
| Records, | w requir | Completed | | | | 24a. Was an perform | autopsy 2 ed? | 4b. Were sutopsy findings available prior to completion of ceuse of death? |
| - R | Physician: The law this certificate has and director, page 2 | mo. | | | | 1□ Ye | s 20(No | 1 ☐ Yes 2 No |
| Vita | Physician: r this certifica rral director, | Be | 25. Wes case referred to medical examiner? | | | ath (Check only one |) | |
| 0 | Physi this o | . To | 1 ☐ Yes 2 ☐ No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Dutp 27. Manner of Death 28a. Date of Injury 28b. Tin | allerii 3LI DOA | | lome 5 Resider | | Specify) |
| 0 | Attending or death. ector: After by the fune | ntion | 27. Manner of Death 1 Death 1 Death 1 Death 1 Death 1 Death 28a. Date of Injury (Month, Day Year) Injury 28b. Tin (Month, Day Year) | ury Wo | ork?]Yes 2 □No | 26d. Describe ho | w injury occurred | |
| Division of Vital | al or Attending Ph s after death. Il Director: After th ed in by the funeral | Certification: | 3 Sulcide 6 Could not be determined 26e. Place of Injury - At home, farm building, etc. (Specify) | , street, factory, office | | 28f. Location (Str. City or Town, | | or Rural Route Number, |
| | To the Hospital or A within 24 hours after 5. To the Funeral Dire completely filled in b | edical C | 29e. Certifier (Check only one) (Check only one) (Check only one) (Check only one) | death occurred et the tor investigation, in my | ime, date and place oplnion, death occu | , end due to the ca rred et the time, da | use(s) and menne te and place, and | er as stated. I due to the ceuse(s) |
| | o the | Σ | 29b. Signature and title of cartifier | 29c. Licen | se number | 29 | d Date signed /A | Anoth Dev Year) |
| | - 5 - 6 | | Val 110 Gods | 7 3 | 137/61 | | 9-4- | -97 |
| , | Car | | 30. Name and eddress of person who completed cause of death (item 23a) (T) NARONG 31. Date filed (Month, Day, Year) 32. Registrar's Signature | /pe, Print) | NEIN | 3,15/ | Fret | 2/201 |
| | Sta | te ar | 31. Date filed (Month, Day, Year) 32. Registrar's Signature PER 1 0 1007 Grand Day Company And Company Com | 001 | ~0) | | - | |



97-5148-510 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. jhm State of Maryland / Department of Health and Mental Hygiene 9.7 DAVID JOSEPH Certificate of Death COOPER 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth **Physician** COOPER JOSEPH DAVID 00:05 AM SEPTEMBER 9, 1997 /Medical 4e. Fecility Neme (If not institution, give street and number, 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner INTERSTATE 295 near CSX RAILROAD BRIDGE BALTIMORE 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1XM 2□ F Months Hours MAR 20,1963 NEW Yrs. 217-84-6075 JERSEV Director Usuel Residence of Decedent 10a Stete 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f show notified at 1 Yes 2 □ No Director MARYLAND the 10e. Street end Number 10g. Citizen of Whet Country? wat be 4383 CREST ROAD **Нете 23**а HEIGHTS USA, 14. Rece - American Indian, Funeral 12. Was Decedent Ever In U,S. Armed Forces?

1 Yes 2 No If Yes, Give Yeer or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Bleck, White, etc. 1 Never Merried 2 Married ö 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 BLACK þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed Decedent's Usuel Occupetion
 (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) marked other than College (1-4or 5+) Hygiene. 12 +H GRADE OFFICE HOVING CO. ABORER 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ages 1 and 2 should be fill not of Health and Mental H: If item 27 Is marked oth Be COOPER JR. DAVID VERDELL DAVIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 4383 CREST HEIGHTS RD., BALTTHORE, HD. 21215 COOPER (MOTHER) VERDELL 20e. Method of Disposition 1 Burial 2 ☐ Cremetion 3 ☐ Removal from Stete permit. Page Department o Important: If any Injury or 9-13-97 ARBUTUS MARYLAND 21. Signeture of Funeral Service Licensee

22. Name and Address of Fecility

23. Name and Address of Fecility

24. Name and Address of Fecility

25. Name and Address of Fecility

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20. Name and Address of Fecility

21. Signeture of Funeral Service Licensee

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29. Name and Address of Fecility

29. Name and Address o Other (Specify) **Physician** /Medical Immediate Ceuse (Finel disease or conditi-resulting in death) Examiner Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or injury that Initieted events resulting in deeth) Last Due to (or es e consequence of) Box 68760 Physician/Medical Due to (or es a consequence of) 200 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. ed by 1 Yes 2 No 3 Probably 4 Phknown Records, þ 8 24b. Were autopsy findings evellable prior to 24a. Was en eutopsy Completed completion of cause of death? 1 Yes TOTAL 2 No of Vital 25. Was case referred to medical examiner? Be 28. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) SCENE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No 27. Menner of Death # 28d. Describe how injury occurred Subject chives from Clarond Struck tokes and way 28c. Injury et Work? 28b. Time of Cartification: Athar Division 1 Natural 2 Accident 5 Pending 28e. Plece of Injury - At home, Term, Street, fectory, office building, etc. (Specify) death. investigation 1 ☐ Yes 2 MNo after death Director: 6 Could not be determined 3 Suicide 4 I Homicide and Assugedis Roadin Beltin are voudwa To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

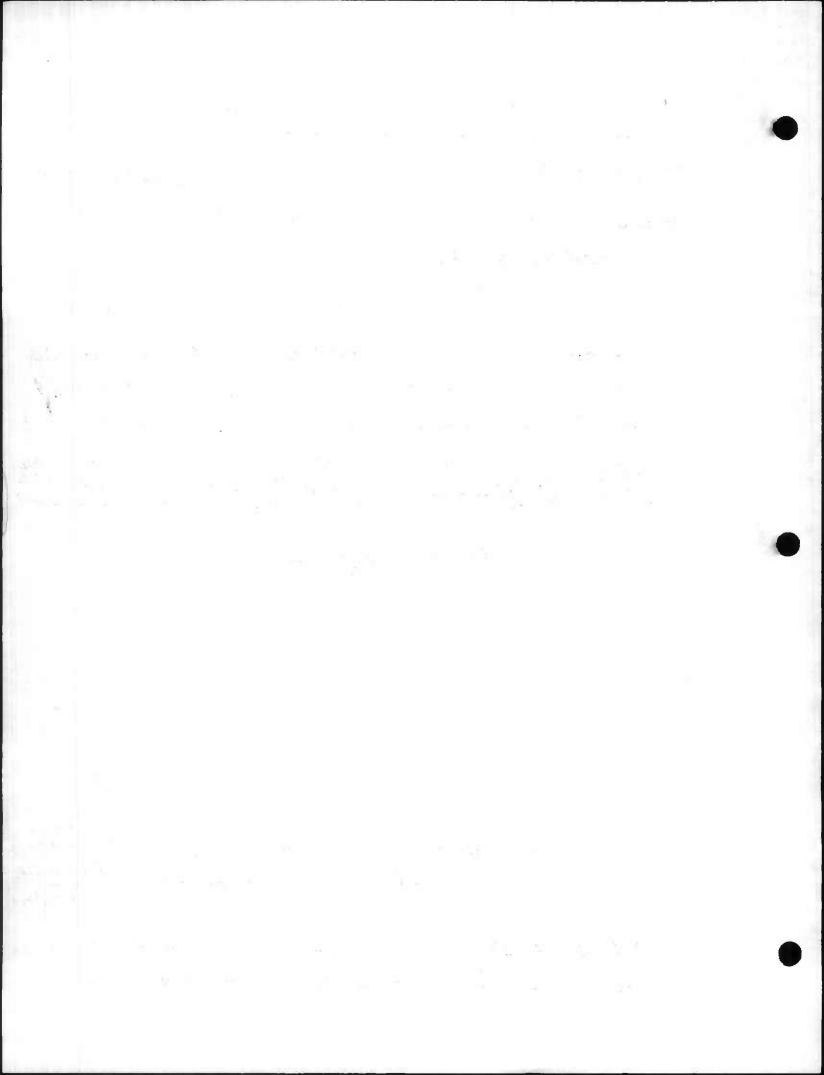
Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signeture end title of certifier 29d. Dete signed (Month, Day, Year) 29c. License number SEPTEMBER 09, 1997 OCME

State Registrar 31. Dete filed (Month, Day, Year)
SEP 101997

Juha David

30. Name end eddress of person who completed causard death (Item 23a) (Type, Print)

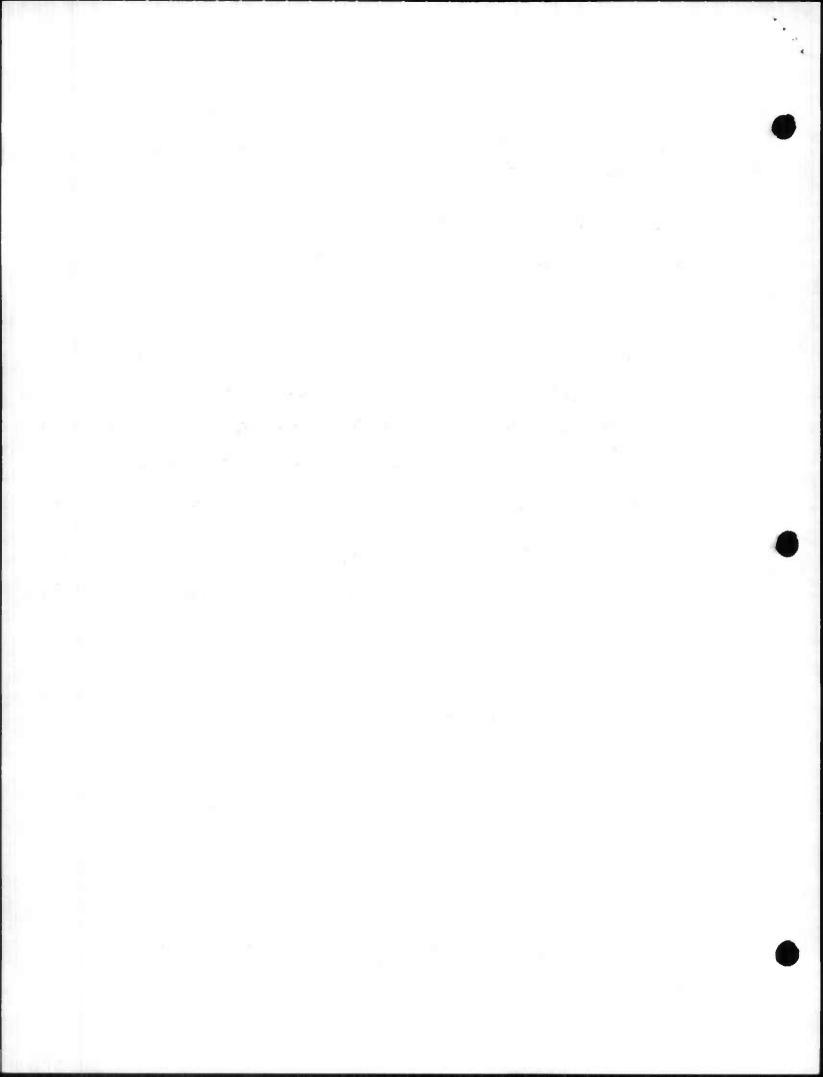
111 Penn Street, Baltimore, Maryland 21201
32. Registyr's Signeture



State of Maryland / Department of Health and Mental Hygiene 9 7

27388

| | | | | | Cer | tificate of | Death | | Reg. No. | | | |
|------------|--|----------------|--|--|-----------------------------|--|-----------------------------|--------------------------------|---------------------------|--------------|-------------------------------------|--|
| | 100 | | 1. Decedent's Name (First, Middle, La | st) | | | | 2. Dete of 0 | Deeth | | 3. Time of Death | |
| | Physic | | PAULINE E. | CARROLL | | | | SEPT | 5 N | 997 | 1-45 _{am} | |
| N | /Medi Examir | | 4e. Fecility Name (If not institution, giv | | | | 4b. City, Town, | or Location of De | | y of Deeth | 1 0 1911 | |
| 4 | LAGIIII | içi | A C | | | | Turan | | | timor | a | |
| Н | Funeral | | 5. Sociel Security Number 6. S | | lest birthday) | If Under 1 Yea | TIMON If Under 24 I | Hrs. 8. Date of F | | | | |
| | Funeral Director | | | □M 20 F 79 | | Months Day: | s Hours N | Hrs. 8. Date of E (Month, I | Dey, Year) | | plece (Stete or Foreign ntry) | |
| | P . | | Usual Residence of Decedent | | | | | | | | | |
| | urylar show | _ | 10e. State 10b. County 10c. City, Town or Location | | | | | | | | | |
| | e M | S S | MD. Baltimo | ere T | IMONIU | m | | | | | 1 □ Yes 2 To No | |
| | E 20 E | Director | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen of | Whet Cour | ntry? | |
| | 23a | | 2457 SPRINGLAK | E DR | | 210 | 293 | | USA | | | |
| | 72 hours after death with the Maryland natural; or items 23a or 28a-f show deal Examiner must be notified | Funeral | 11. Maritai Status | 12. Wes Decedent Ever In U Armed Forces? | ,S. 13. V | Vas Decedent of Yes, specify Cu | Hispanic Origin's | (Specify Yes or I | No- 14. Ra | ca - Americ | | |
| 0 | or is | | 1 Never Married 2 Married | 1 ☐ Yes 2 ☑ No | | □Yes 2 No | | 20110 7110011, 010.7 | Speci | | etc. | |
| 000 | iral', | d by | 3 Widowed 4 Divorcad | Year or Dates: | | | у орошу. | | Speci | WHI | TE | |
| 21215-0020 | permit. Pages 1 and 2 should be flied within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Med cal Examiner must be notified and another. | Completed | 15. Decedent's Ed (Specify only highest gra | ducation ade com <i>pleted)</i> | 16e. Deced | lent's Usuel Occu kind of work done OO NOT use retir | upetion e during most of | working | 16b. Kind of E | Business/In- | dustry | |
| 121 | within iene. | Idu | Elementary/Secondary (0-12) | College (1-4or 5+) | _ | | ed) | 376 | 0 | | | |
| | filed v Hygie ther ti | ပ္ပ | 12 | Printings. | Se | cretary | | | Liot | hing | | |
| ī | be fi | Be | 17. Fether's Name (First, Middle, Last) | | | | | Neme (First, Midd | | me) | | |
| 3 | Men Men mrke | 2 | | ROLL | | | ELL | EN MA | MNING | | | |
| Maryland | 2 she and is m | | 19e. Informant's Name/Reletionship (| Type, Print) | | | | Rurel Route Num | ber, City or Town | , Stete, Zip | Code) | |
| | Health Health em 27 | 6 6 | JOAN MILLIAN | | 245 | | NGLAKE | | imoniur | | | |
| Ore | of H of H or oth | | 20a. Method of Disposition 1 □ Buriai 2 🕱 Cremation 3 □ | | lece of Disposemetery, crem | sition (Neme of netory or other pl | eca) | Sept 8 | 20c. Location | - City or To | own, Stete | |
| E | Pagas ment of I ant: If its ury or o | | 4 Donation 5 Other (Specify | | een Ma | unt Cem | etery | 1997 | Baltimo | ere. M | ld | |
| Baltimore, | permit. F Departm Importar any injur | | 21. Signature of Funeral Servica Licar | | | . Name and Add | | | | | | |
| m | 80 = 20 | | Rep 1100 |)() | E. | | M.2 | 23 | 25 York Re | T | | |
| | | | 23a. Part1. Enter the disease, or conshock, or heert feilure. List only | pications that caused the deati | h. Do not ente | ANS CHAPS or the mode of dy | ing, such as car | diac or respiratory | arrest, | | Approximete | |
| | Physician | | SHOCK, OF HEER TEHLIFE. LIST ONly | one cause on each line. | | | | | | 1 | Interval Between Onset end Death | |
| a | /Medical | | Immediete Cause (Final disease or condition | CANCUST | 12/15 | Han | - (-12 | | | | YRS | |
| | Examiner | | resulting in death) | e. Concest | r es a consen | neuca ot). | (10) | LUTUR | | | 7103 | |
| | | ner | | b. CHrome | 0000 | 1 01 | | DIA | | | YRC | |
| | erricate be executed ling physician and | Examiner | Sequentially list conditions | Due to (o | r es e consequ | uence of): | cm. | 21861 | 136 | | 1105 | |
| 0 | B ar | | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying | | _ | | | | | | | |
| 68760 | 8 10 8 | ca | Cause (Diseese or injury thet initiated events | cDue to (or | r as a consequ | uence of): | | | | | | |
| | 20 00 41 | Medical | resulting in deeth) Lest | | | , | | | | 1 | | |
| Box | andra or | N/UE | | d | | | | | | 1 | | |
| 1 | | Physician | Part II. Other significant conditions of | ontributing to death but not resi | ulting In the ur | nderlying cause g | iven in Part I. | 23b. Di | d tobacco uae ce | ontribute te | o the cause of death? | |
| 8 | 9-69 | پر | | | | | | 11 | TYee 2□No | 3 Pro | bably 4 Unknown | |
| - 7 | | by F | CARCINO | ma Esop | MAG | 03 | | - | | | | |
| Records | de de | | | | | | | 24e. We | es en eutopsy rformed? | | ere autopsy findings | |
| 00 | aw requisits been 2 should | pjet | | | | | | | nonnea i | CO | mpletion of cause deeth? | |
| | 9 4 8 | Completed | | | | | | 1 | Yes 2⊟No | 1.1 | ☐ Yes 2☐ No | |
| Viital | | | 25. Was case referred to medical | | | | 26 Place of | Deeth (Check only | | 10 | 2010 | |
| | | o Be | examiner? 1 ☐ Yes 2 ☐ No | Hospital: 1 ☐ Inpatient 2 ☐ | ER/Outpatlen | t 3□ DOA O | ther: | g Home 5 Re | | her (Specif | 6.1 | |
| o | Phys rthis aral d | - | 27. Mennes of Death | 28a. Date of Injury | 28b. Time of | 28c. Inj | | | e how injury occu | | γ/ | |
| Division | or Attending after death. Director: After in by the fune | tio | 1 ■ Naturel 5 ■ Pending 2 ■ Accident Investigation | (Month, Dey Year) | Injury | | ork?]Yes 2 ☐ No | | | | | |
| 2 | death death ctor: A | flca | 3 Suicide 6 Could not be | | ome, farm, stre | et, factory, office |) | 28f. Location | (Street end Num | ber or Rure | al Route Number, | |
| ā | aftar Direct | Certification: | 4 Homicide | building, etc. (Specify | v) | | | City or T | own, Stete) | | | |
| | spita nours neral | | 29a. Certifier 1 Certifying Ph | ysician: To the best of my know | wledge, deeth | occurred et the | time, date and pl | eca, end due to th | e cause(s) end m | anner as s | stated. | |
| | Fur fetely | edical | (Check only 2 Medical Exam | niner: On the basis of examiner and manner state. | tion end/or inv | estigetion, In my | opinion, deeth o | ccurred at the time | e, date and plece | , end due to | the ceuse(s) | |
| | To the Hospital or Attending Ph within 24 hours aftar death. To the Funeral Director: After th completely filled in by the funeral | Me | 29b. Signature end title of certifier | _ \(/) | | 29c. Licer | se number | | 29d. Dete sign | ed (Month, | Dey, Year) | |
| | , , , , | | 1/: | AAV. | 6.2 | D | 288 | 17 | 910 | 19- | | |
| | 1. | | 30. Name end address of person who | completed cause of death (item | 23a) (Tuna 4 | Print) | | | 113 | 111 | | |
| | V | | Vincent 1. F | 11 1RD - 781 | 11 4 | PK K | 1 111 | WSON, | mn | 2120 | 14 | |
| | Sta | te | 31. Date Hay (Month Day Year) | 32. Register's Signa | Me | 1 / // | | wool, | 1110. | 100 | -1 | |
| | Registr | | oel I a 1881 | Juna wardson- | Janacias | | | | | | | |



Please Type or Print in Black Indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27389 Certificate of Death 1. Decedent'e Neme (First, Middle, Laşt) 2. Dete of Deeth 3. Time of Deeth NIWERS Month CATNES 400 pm 4e. Fecility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Genesis Mouti Medical BACTIMORE Center TOWSON If Under 1 Yaar Months Days If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthpleca (Steta or Foreign Country) 5. Sociel Sacurity Number 7. Age (In yrs. lest birthdey) Days 219-01-1839 1985,M 2□ F Yrs April 23,1914 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yes 2 No Md. SPARKS BALTO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14221 Dove Creek Way

11. Meritel Stetus

12. Was Dacedant Evar In U.S.

Armed Forcas? USA 21152 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 11. Meritel Stetus 1 MYas 2 No If Yes, Give Year or Dates: WW. I 1 Never Merried 2 ☐ Merried 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced WHITE 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) 6 Security GAURD STATE of Maryland 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Cornes EDWIN IDA Holland 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14221 Dove Creek Way Spark 3 Md 21152
of Disposition (Name of peta peta 20c. Location - City or Town, State pry, cramatory or other place) Donald W. Carnes 20b. Plece of Disposition (Neme of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - Cify or Town, Stete 1 Burial 2 ☐ Cramation 3 ☐ Removel from Stete OUDON PARK Cemetery
22. Nama and Address of Facility 4 ☐ Donetion 5 ☐ Other (Specify) Balto. Md 1997 21. Signature of Funeral Service Licen 23a. Pert1. Enter the diseasa, or complication; that caused the deeth. Do not antar tha mode of dying, such as cardiac or respiratory errest, Approximate Interval Between Onset and Deeth Immediate Ceuse (Finel A SUS hours disaese or condition resulting in deeth) Due to (or es a consequence of) rears Sequentially list conditions, if any, leeding to immediate cause. Entar Underlying Ceuse (Disease or injury that initieted events rasulting in death) Last Due to (or es e consequence of): Dua to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? P.V.D 1 ☐ Yas 2 No 25. Wes case referred to medical examiner?
1 ☐ Yes 2 No 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28e. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 3 ☐ Suicide

Physician /Medical Examiner buriel-transit and physician s s the burief Box 68760. 980 Vital Records, P.O.

Physician

/Medical

Examiner

Director

Funeral

à

Completed

Be

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examinar must be notified at

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be lited within Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumeth.

or items

Physician/Medical ğ page 2 should Completed cate 8 Certification: To

The Hospital

4 Homicide

SEP 1 0 1997

29a. Certifler (Check only one)

Division of

within 24 hours after death To the Funeral Director: a completely lilled in by the fi

State Registrar

Medical

1% Certifying Physician: To the best of my knowledge, death occurred at the time, dete and piece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signature and title of a tiffier Medical

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Old PU# 203. Balfo Md 21208 DUNT 31. Dete filed (Month, Dey, Yeer) 32 Registrer's Signature Like Davidson-Randelle

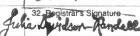
State of Maryland / Department of Health and Mental Hygiene 97 27390

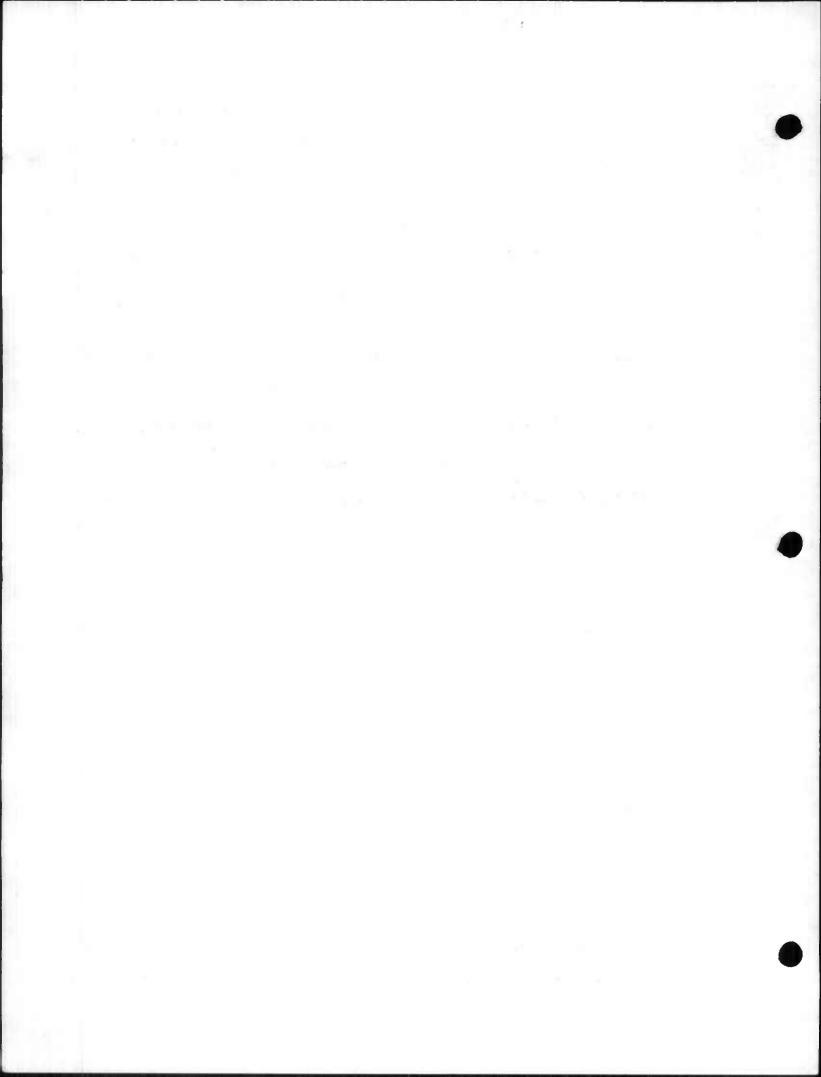
Certificate of Death

| | | | | | | | Uer | uncale | UI | Deam | | | Reg. I | No. | | | |
|-----------------------|--|-----------------------|---|---|-----------------------------------|---------------------|-----------------------------|------------------------------------|---------------------|---------------|------------|--|-----------------------------|------------------------------|--|--|-----------------------------|
| | Physic /Medi | | 1. Decedent's Name (First, Middl THELMA EVELYN | | | | | | | | | 2. Date of D Month SEPT | eeth | Day 199 | Year | | e of Death |
| | Exami | | 4e. Fecility Name (If not institution CHESAPEAKE HEA) | | umber) | | | | | 4b. City, To | | ocation of Dea | on of Death 4c. County of D | | of Death | DEI | |
| | Funeral Director | | 5. Social Security Number 214-01-2534 | 6. Sex 1 ☐ M 2 ☐ F | 7. Age | e (In yrs. lest bir | thday) Yrs. | If Under 1 Months | Year Days | | | 8. Date of Birth (Month, Day, Yeer) SEPT 17,1920 | | er) | 9. Birthp Coun | | ite o <i>r Foreign</i> |
| | aryland show dist | | Usual Residence of Decedent 10a. Stete 10b. County | | | 10c. City, Town | n or Lo | cation | | | | 0011 | | 1,20 | | 0d. Inside | e City Limits |
| | ith the Maryland or 28a-f show | Director | 10e. Street and Number | E ARUNDEL | | PAS | SADE | ENA 10f. Zip C | ode | | | | 10g. | Citizen of V | 1 ☐ Yes 2 1 No of What Country? | | |
| | 23a | 20 | 7651 BETH NOELI | LE COURT | | | | 2 | 112 | 22 | | | | U.S. | A. | | |
| 020 | be filed within 72 hours after death with the Maryland stal Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Exercicer must be notified at | by Funeral | 11. Maritel Stetus 1 Never Married 2 Marr 3 X Widowed 4 Divorced | H Voc G | Forces? 2 (XIN Sive | | | Vas Deceder Yes, specify | | | | ecify Yes or N Rican, etc.) | 0- | Biad | 4. Race - American Indian, Black, White, etc. Specify: WHITE | | i, |
| 5-0 | 72 h | ig B | 15. Deceden (Specify only higher | t's Education | f) | 16a. | Deced (Give | ent's Usuai | Occup | ation | t of work | ina | 16b. | Kind of Bu | usiness/înc | dustry | |
| 21215-0020 | od within giene. er than | Completed | Elementary/Secondery (0-12) 6TH GRADE | College | | +) | | kind of work OO NOT use IIER | retire | d) | I OI WOIK | mig | | FOOD | STOR | STORES | |
| pu | be filed tal Hygie d other event, tr | Be (| 17. Father's Name (First, Middle, | Last) | | | | | | 18. Mothe | er's Neme | e (First, Middle | e, Maid | len Suman | 10) | | |
| Maryland | should by | 2 | Louis Chaffman | | | | | | | Ed | ith | Rutter | | | | | |
| Jar | 2000 | | 19a. Informant's Neme/Relations | | | 19b. | Meitin | g Address (| Street | end Numbe | er or Run | al Route Num | ber, Cit | y or Town, | State, Zip | Code) | |
| altimore, | permit. Pages 1 end 2 should Department of Health end Mer Important: if item 27 is marke any injury or other traumetic ance. | | Bonnie Zinkand 20a. Method of Disposition 1⊠ Burial 2 □ Cremetion 4 □ Donation 5 □ Other (Si | 3 □Removal from | | | Dispos y, crem | sition (Neme netory or oth | of er pla | ce) | 9 | Date /8/97 | 20c. | dena, Location - ELKRI | City or To | | |
| Balti | pemit. Page Department of Important: If any injury or once. | | 4 Donation 5 Other (Specify) Meadowridge Memorial Park 21. Signature of Funetal Service Licensee HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE—BALTIMORE, MD 21229 | | | | | | | | | | | | | | |
| | Physician | | 23a. P. VV. Enter the disease, or heart failure. List | complications that only one cause on | ceused each lin | the death. Do r | | | | | | | | E, MD | 21 | Approxir Interval | mate Between nd Death |
| 1 | /Medical Examiner | | Immediate Cause (Final disease or condition resulting in death) | a | | PSIS | | | | | | | | | 2 | 2 W | eeks |
| | uted d ansit | Examiner | Immediate Cause (Final disease or condition resulting in death) Due to (or as e consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Influry Ceuse (Disease or Influry) PERIPHENAL VASCULAR DISEASE 17BAR | | | | | | | | | | | | | | |
| 68760, | certificate be executed nding physician end use as the buriel-transit | | that initiated events | | | | | | | | | | | AR | | | |
| ŏ | h certifica ending ph | an/Medical | resulting In deeth) Last | d | | , | | | | | _ | | | | 1 | | |
| | deat ed fo | sicis | Pert II. Other eignificent condition | ns contributing to d | death bu | it not resulting in | the un | deriying ceu | se giv | en in Pert I. | | 23b. Dio | tobac | CO USE COI | ntribute to | the cau | se of death? |
| s, P.C | Applies that the death en signed by the etter aulid be detached for a | by Phy | CONGRITIN | 1B_ (| SR. | ART | FA | 712 UR | 3 | Ma. | | 1 | Yes | 2□ No | 3 Prot | oably 4 | Unknow |
| Vital Records, P.O. B | an require | Completed by Physicia | | | | | | | | | | 24a. We | s an au formed | topsy | eva | ere autop aliable pri mpletion death? | |
| 9 | 4 | Son | | | | | | | | | | 1 🗆 | Yes | 20 No | 10 | Yes : | 2□ No |
| =/ | 1 1 | Be | 25. Was cese referred to medicel examiner? | | | | | | | 26. Plece | of Deet | (Check only | one) | | | | |
| n of | ng Physic fter this cureral dire | 10 | 1 ☐ Yes 2 No 27. Manner of Death 1 ☑ Natural 5 ☐ Pendin | 28a, Dete | Inpatier of Injur- oth, Day | y 28b. T | tpatient ime of njury | 280 | Oth Injur Wor | y at rk? | | me 5 Res 28d. Describe | | | | 1) | |
| Division of | To the Hospital or Attending Physimitin 24 hours effer death. To the Funeral Director: After this of completely filled in by the funeral directors. | Certification: | 2 Accident Investig 3 Sulcide 6 Could r 4 Homlcide determ | M et, factory, o | 1 ☐ Yes 2 ☐ No | | | | | | | | | | | | |
| _ | Hospital 4 hours a Funeral E tely filled | edicai Ce | (Check only 2 Medical I | g Phyeician: To the Examiner: On the b | basis of | examination end | , death | occurred et estigation, in | the tir | me, dete en | d place, a | and due to the | ceuse | (s) end ma | nner as st | eted. | se(s) |
| | ithin the | Med | one) 29b. Signeture and title of certifier | end mar | nner stat | ted. | | | | e number | | | | Dete signe | | | |
| | (| _ | ▶ Whymae | My Atte | | | | 1 3 | D. | 216 | | | | 9- | 6 - 9 | 77 | |
| | K | | 30. Name end eddress of person of C-V-CYRIAC- | M-D 8 | 10° | eath (Item 23a) (| Type, F | Print) | + Cu | 7, 7 | DAS | AOEN | IA | 17 | 0 0 | 112 | 2 |

State Registrar

31. Date flied (Month, Day, Year) SEP 1 0 1997





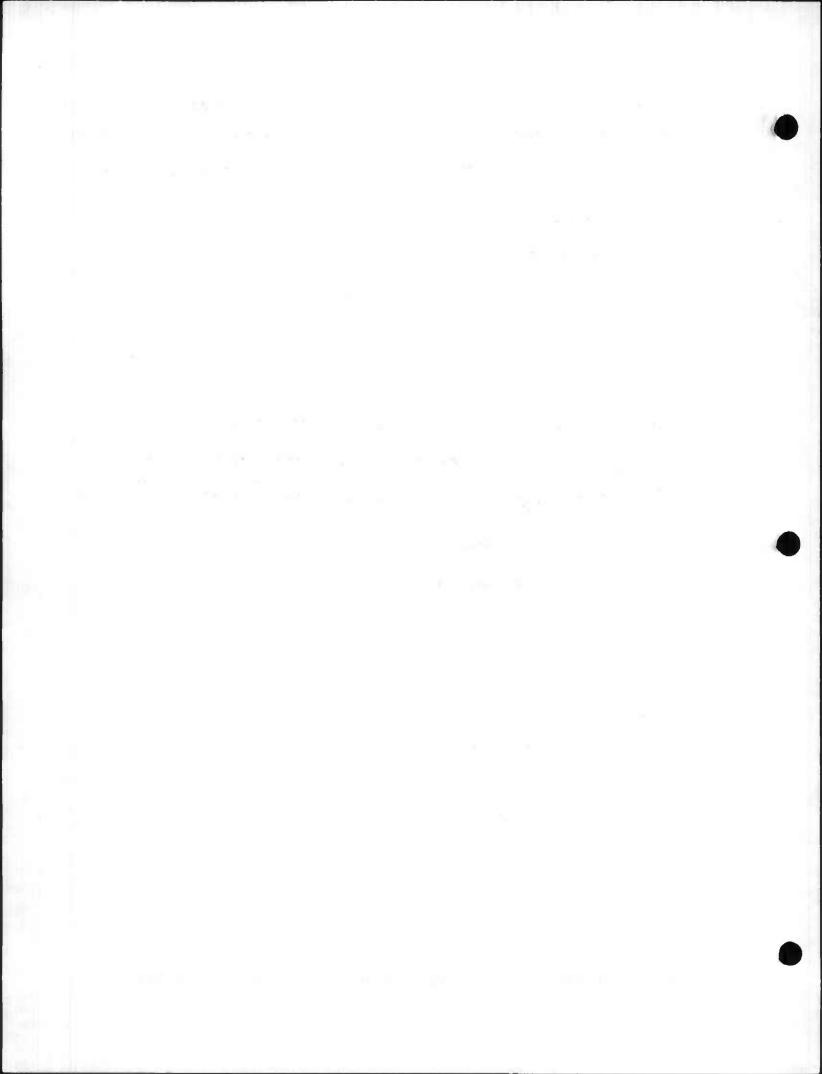
State of Maryland / Department of Health and Mental Hygiene 97

27391

| | | | | | Certi | ficate | of Death | | Reg. No. | N Same I | 031 | |
|--|------------------|--|---|--------------------------|--|---|---|---|-----------------------------------|--|--|--|
| | sician edical | Decedent's Name (First, Middle, ETHEL | Last) | DOL | _L | | | 2. Date of De SEPTEME | ath | Year | Time of Death | |
| | miner | 4a. Facility Name (If not institution, Saint Josep | give street and numbe h Medical | Cer | nter | | 4b. City, Town, or Tow | | h 4c. County | of Death Baltin | iore | |
| Fune Direc | | 214-12-2359 | 6. Sex 1□M 2√F 7. A | 77 | | If Under 1 Y Months D | ear If Under 24 Hr ays Hours Mir | | th 1920 | 9. Birthplace Country) MD | (State or Foreig | |
| yland | | Usual Residence of Decedent 10a. State 10b. County | | 10c. Ci | ty, Town or Locat | ion | | | | 10d. Ir | nside City Limits | |
| e Mar | Director | MD HOWA | RD | | MARRIOTI | SVILI | Æ | | | 1 | □Yes 2∏No | |
| ith th | S S | 10e. Street and Number | | | | 10f. Zip Co | de | | 10g. Citizen of | en of What Country? | | |
| ath w | la la | | | | | | 1104 | | | U.S.A. | | |
| positinition of the property o | by Funeral | 3 ∰Widowed 4 □ Divorced | Armed Forces d 1 Tes 2 If Yes, Give | 1 Tyes 2 ANO | | Nas Decedent of Hispanic Origin? (Specify Yes of Yes, specify Cuban, Mexican, Puerto Rican, etc I ☐ Yes XXNo Specify: | | | Bla Specif | ce - American Inck, White, etc. y: WHITE | | |
| Mailyianiu A.1.2.1.5-UU.2.0.2.0.2.0.2.0.2.0.2.0.2.0.2.0.2.0.2 | Completed | 15. Decedent's (Specify only highest Elementary/Secondary (0-12) | Education grade completed) College (1-4o | r 5+) | 16a. Deceden (Give kin life. DO HOMEMAK | NOT use r | Occupation done during most of working retired) | | 16b. Kind of Business/Indu | | | |
| High parent | Ü | | ast) | | 1101111111 | | 18. Mother's Na | me (First, Middle | - | | | |
| ld be fental ked c | To Be | ALBERT HENRY TU | CKER | | | | ALIC | E VIOLA | PIERCE | | | |
| s me | | 19a. Informant's Name/Reletionshi | p (Type, Print) | | 19b. Mailing A | Address (S | reet end Number or F | Rural Route Numb | er, City or Town | State, Zip Code |)) | |
| and and and and and and and and and and | | ANDREW BEEBE/ P | .O.A. | | | | | WINGS MI | LLS, MAI | RYLAND 21117 | | |
| Dearthing Co., Semit. Pages 1 at Department of Heam moortant: if item. | 3 | 20a. Method of Disposition 1 | B □Removal from Stat | | Place of Disposition of Place of Disposition of Place of Disposition of Place of Place of Place of Place of Place of Place of Place of Disposition of Disposition of Dis | on (Name of other | of r place) | Date | | | | |
| t. Pa thmen tant: | | 4 ☐ Donation 5 ☐ Other (Spe | acity) | | | | GARDENS | 9/11/97 | | | , MD | |
| Depart | ouce | 21. Signature of Fureign Service Li | All | | 736 | EDMC | ddress of Facility ASHTON FU NDSON AVE | . CATONS | VILLE, N | C. MD 2122 | :8 | |
| | | 23a. Part. Enter the disease, or shock, or heart failure. List o | omplications that cause niverse cause on each | ed the dear line. | th. Do not enter t | he mode of | dying, such as cerdia | ac or respiratory a | rrest, | Inter | roximate val Between | |
| Physicia /Medic Examin | cal | Immediate Cause (Finel disease or condition resulting in death) | RESP I | | DRY FAI | | | | | Ons | et and Death | |
| D & | ner ne | | PNEUM | 10NI A | or as a consequer | nce on. | | | | | | |
| and -trans | Kam | Sequentially list conditions, | | | | | | | | | | |
| be ex ician | <u>a</u> | Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury | C | | | | | | | | | |
| eath certificate be executed attending physician and for use as the bunk-fransit | Medical Examiner | that initiated events resulting in death) Last | | Due to (d | or as a consequer | nce of): | | | | | | |
| ath cert | an/M | | | | | | | | | | | |
| the dea y the at | Physician | Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco uas contributa to the | | | | | | | | | | |
| that the death led by the atter detached for the | | RENAL FAILU | JRE | | | | | 10 | Yss 2□ No | 3 Probably | 4 Unknow | |
| v requires been sign should be | leted b | CORONARY AI | RTERY DIS | EASE | | | | 24a. Wes | en eutopsy prmed? | avallable | utopsy findings a prior to ion of ceuse ? | |
| - w w | E O | | | | | | | 10 | Yes 2 No | 1 ☐ Yes | 2 % No | |
| ysician: The scertificate director, pag | BeC | 25. Was cese referred to medicel examiner? | | | | | 26. Place of De | eath (Check only | one) | | | |
| 2 00 | | 1 Yes 2 No | Hospital: | tient 2 | ER/Outpatient | 3□ DOA | Other: 4 ☐ Nursing | Home 5□ Resi | dence 6 □Oth | ner (Specity) | | |
| ing Ph ing Ph | 00: | 27. Manner of Death 1 SNatural 5 ☐ Pending | 28a. Date of In (Month, D | jury ay Y <i>ear)</i> | 28b. Time of Injury | 28c. | Injury at Work? | 28d. Describe | how Injury occur | red | | |
| or Attending after death. Director: After d in by the fune | Certification: | 2 Accident investige 3 Suicide 6 Could no 4 Homicide determin | 1 ☐ Yes 2 ☐ No ory, offica 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| Franch Park | edical Ce | 29a. Certifier (Check only one) Cartifying 2 Medical Ex | Phyalcian: To the bes | of exemine | owledge, death oc etlon end/or invest | ccurred at th | ne time, date end plec my opinion, deeth occ | e, and due to the urred et the time, | cause(s) and m dete end plece, | anner as stated. and due to the o | euse(s) | |
| S S S S S S S S S S S S S S S S S S S | Me | 29b. Signature and title of certifier | ma | Tho | ט | | cense number 30263 | | | od (Month, Day, | Year) | |
| 26 | | 30. Name end eddress of person w | | | | | | | | | | |
| -0. | | FRANCIS KHOO | M. D. 76 | 50 / | ORK RO | AD | TOWSON M | ARYLAND | 21204 | - | | |

State Registrar 31. Date filed (Month, Day, Year) SEP 1 0 1997

32. Registrar's Signature



| | | | State of Maryland / D Item: 19aper F.H.G-753 11/4/97 reb | epartment of F Certificate of | | , , | jiene g | 7 27392 |
|----------------------------|---|---------------------|---|--|--|--|-------------------------------------|--|
| | | | 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Dea | th | 3. Time of Death |
| | Physici /Medi | | Alice Margaret Domino | | | SEPTEM | BER 5 | 1997 5:20 AM |
| | Examir | | 4a. Facility Name (If not institution, give street and number) | | 4b. City, Town, or Lo | | 4c. County | |
| | | Ш | Saint Joseph Medical Center | | Tows | | | Baltimore |
| | Funeral Director | | 5. Social Security Number 212-18-5318 6. Sex 1 M 2 K 81 7. Age (In yrs. last birth 81 Y | nday) If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day March 2 | 0, 1916 | 9. Birthplace (State or Foreign Country) Maryland |
| Jul M | within 72 hours after death with the Maryland ena. than "natural", or items 23a or 28a-f show na Medical Exertine frust be notified at | tor | 10e. State 10b. County 10c. City, Town | or Location ville | | | | 10d. Inside City Limits 1 ☐ Yes 2 🕅 No |
| 3 | or 28a-f | Olrec | 10e. Street and Number | 10f. Zip Code | | 1 | 0g. Citizen of W | hat Country? |
| 2 | ath w | ral | 7-F Mopec Circle | | 236 | | U.S. | |
| 20 | permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiena. Important: if itam 27 is merked other than "natural; or items 23a or any Injury or other traumatic event, tra Medical Exprinter must be once. | by Funeral Director | 11. Marital Status 1 Never Married 2 Married 1 Ves 2 Xo 1 Ves 2 Xo 1 Yes, Give Year or Dates: | 13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 🌂 ☐ No | | ecify Yes or No- Rican, etc.) | | - American Indian, K, White, etc. |
| , 8 | hour | ed t | Λ | Decedent's Usual Occur | nation | | 16b. Kind of Bus | White |
| //CE | nin 72 n "n | Be Completed | (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) | Decedent's Usual Occup 'Give kind of work done life. DO NOT use retire | during most of worki | ing | 700. 11110 01 001 | on our was try |
| 212 | giena giena er tha | E O | | Homemaker | | | Ho | me |
| A B | be file d othy | Be (| 17. Father's Neme (First, Middle, Last) | | 18. Mother's Name | | | 9) |
| ∑ <u></u> | Men Men mrke | To | Rosario Squatrito | | Catherin | | hera | |
| H Maryland | and 2 sh ealth and m 27 ie m | | Rosemarie Battaglea (Daughter) 7- | Meiling Address (Street F Mopec Ci) | rcle Parkv | /ille, M | laryland | 21236 |
| Baltimore, | Pages 1 ment of H ant: If Ital ury or ott | | M builet 2 Dotemation 3 Diremoval from State | Disposition (Name of crematory or other pla Hill Cemete | | | | e, Maryland |
| Balt | permit. Depart Import any inj | | 21. Signature of Fungre Service Licansee Kevin E. Ecker | MCCully-Po 237 E. Pat | | | | 21225 |
| | 45 (173) | | 23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. | | | | | Approximate Interval Between |
| • | Physician /Medical Examiner | H | Immediate Cause (Final disease or condition | | | | | Onset end Deeth YEARS |
| | | iner | resulting in deeth) Due to (or as a co | onsequence of): | | | | |
| 90, | eta be executed hysician and the burial-transit | ıi Examiner | Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury c. | onsequence of): | | | | |
| Box 68760, | eeth certificeta t ettending physic for use es the b | Physiclan/Medical | that initiated events resulting in death) Last Due to (or as a co | nsequenca of): | | | | |
| . B | deeth e ette | sicla | Part II. Other significant conditions contributing to death but not resulting in | the undertying cause give | ven in Part I. | 23b. Did to | bacco use con | tribute to the cause of death? |
| s, P.O. | v requires that the deeth certific been signed by the ettending p should be detached for use es | by Phys | | | | 1□ Y | es 2 No | 3 Probably Unknown |
| Division of Vital Records, | Attanding Physician: The law requires that the deeth certifice redeath. sctor: After this certificata has been signed by the ettending ph by the funeral director, paga 2 should be detached for use es the standard for use sets. | Completed b | | | | 24a. Was a perfor | n autopsy med? | 24b. Were autopsy findings evallable prior to completion of cause of death? |
| <u> </u> | The la | EO | | | | 1 🗆 Y | ea 275No | 1 ☐ Yes 2 No |
| ita | ysician: The lav is certificata has director, paga 2 | Be (| 25. Was case referred to medical examiner? | | 26. Placa of Death | (Check only or | re) | |
| of C | Physic this ce | 2 | 1 ☐ Yes No Hospitel: 1 Inpatient 2 ☐ ER/Out | Delient 3LI DOX | ner: 4 Nursing Ho | | | |
| sion o | Attanding Phir death. ector: After thi by the funeral | Certification: | 2 ☐ Accident investigation | ury Wo | ryet rk? ∣Yea 2⊡No | 28d. Describe h | ow Injury occurre | ed |
| Divis | o de la | Certifle | 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Placa of Injury - At home, fan building, etc. (Specify) | m, street, factory, offica | | 28f. Location (S City or Town | | er or Rurel Route Number, |
| | A House in 24 hours Front His | edical | 29a. Certifier (Check only one) Check only one) Certifying Physician: To the best of my knowledge, 2 | death occurred at the the or investigation, in my o | me, date and placa, a opinion, death occurr | and due to the c ed at the time, d | ause(s) end mar ate and place, a | nner es stated. nd due to the cause(s) |
| | (群) | Σ | 29b. Signeture end title of cartifier To melle mo | 29c. Licens D 4 | 1410 | | 9d. Date signed | (Month, Dey, Yeer) |
| | 15 | | 30. Name and oddress of person who completed cause of death (Item 23e) (T | ype, Print) | DAD TO | | | ND 21204 |
| | Sta | te | 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture | | | | | |

DHMH 16 Rev 6/95

State

Registrar

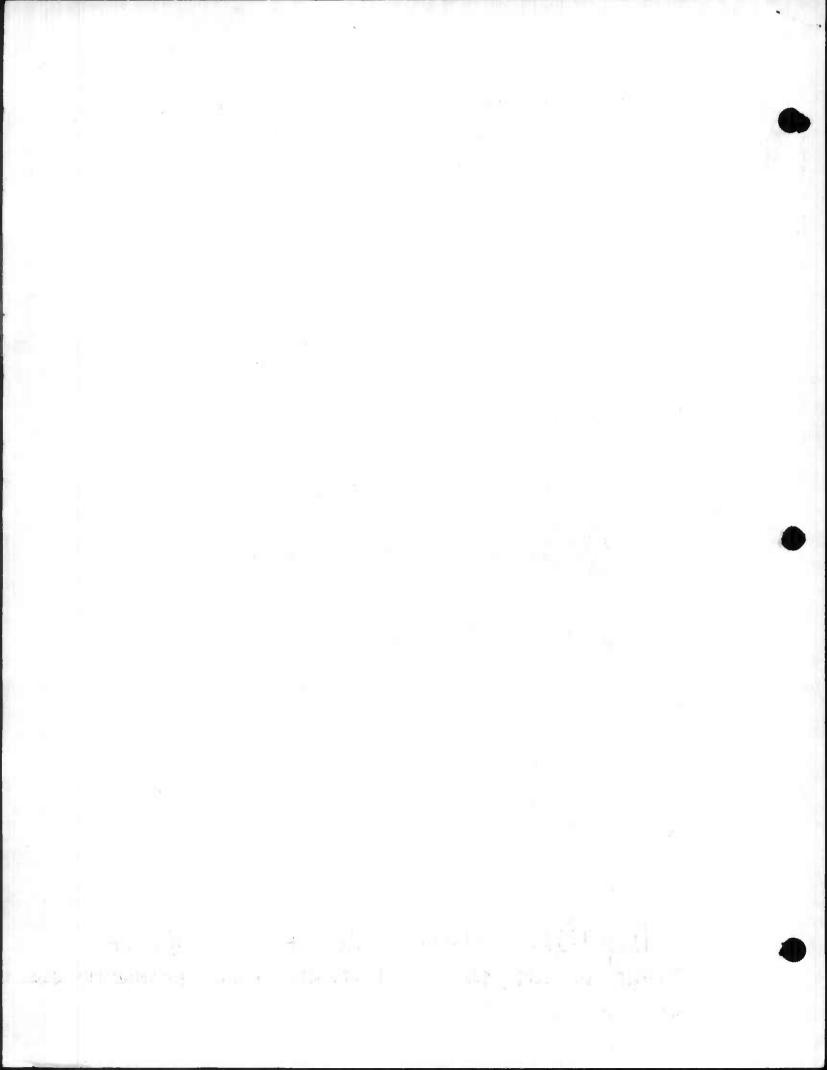
SEP 1 0 1997

1 T

| Please Type or Print in Black Indelible Ink. Assure All Copies Are I | Legible. |
|--|----------|
| State of Maryland / Department of Health and Mental Hygiene | 97 |

27393 Certificate of Death Reg. No. 1. Dacedent's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death Month **Physician** ELEANOR FRANCES DAVIS SEPTEMBER 6, 1997 /Medical 2:05 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Stella Maris At Mercy Hosp. Baltimore N/A If Undar 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Funerai Birthpiaca (State or Foreign Country) 1□M 2√3 F Months Days 72 Yrs. Nov.9,1924 Director 219-12-8763 Maryland Usual Residenca ot Decedent death with the Maryland 10b. County 10c. City. Town or Location or 28a-f show 10d. Inside City Limits "natural", or items 23s or 28s-f shoved call Examiner must be notified at Baltimore Md. Edgemere Director 1 ☐ Yas 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen ot What Country? 2825 Lodge Farm Rd. 21219 USA Funeral 11 Marital Status Was Dacedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American indian, Black, White, atc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itel may Injury or other traumatic event, tra Medical Extensional pages. 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yes 2 No It Yes, Give 1 ☐ Yes 2 🛣 No Specify: Specify:White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) 12 yrs. Coilege (1-4or 5+) Housewife Home 17. Father's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surname) Be Edward Ward Eleanor McCubbin 2 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Joseph K. Davis Sr. 2825 Lodge Farm Rd. Edgemere Md. 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method ot Disposition 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Removal from Stata Garrison Forest V.A. 9-10 Owings Mills 4 ☐Donation 5 ☐ Other (Specify) Signatura d 22. Nama and Address of Facility Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 23a. Part. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tellure. List only one cause on each line. Approximata ervel Bety Onset and Death **Physician** /Medical . Kecure Immediate Cause (Finel disease or condition resulting in daath) Examiner Due to (or as a consequenca ot) Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initieted events rasulting in death) Last Due to (or as a consequenca of) hat the death certificate be Physician/Medical # Dua to (or as a consequence of) attending 35 peq Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ed by the 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy tindings availabla prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 Yas 2 No Division of Vital or Attending Physician: after death. Director: After this certific 25. Was case reterred to medical 26. Plece of Death (Check only one) STELLA MARIS AT MERCY Be Hospital: 1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidance 8 ØOther (Specify) HOSPICE 2 1 ☐ Yes 2 No 28a. Dete of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of injury 28d. Describe how injury occurred 28c. Injury at Work? t Netural 5 Pending 1 ☐ Yas 2 ☐ No 2 Accidant investigation 3 Sulcide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, tarm, street, factory, offica building, etc. (Specify) 4 - Homleide To the Hospital of within 24 hours a To the Funeral D completely filled in 29a. Certifier (Check only one) Certifying Physictan: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and place, and dua to the cause(s) and manner stated. Medical 29b. Signature and title of 29c. License number 29d. Date signed (Month, Dey, Year) M(1)30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print) ,M.D. ST. PAUL PLACE, BALTIMORE MD 2/202 DWIGHT IM 301 31. Dete tiled (Month, Dey, Year) State SEP 1 0 1997 Registrar



WRC 975078-510 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. ANTHONY State of Maryland / Department of Health and Mental Hygiene DEPONTES Items:23a Part I.27,28a-f per MEO G-751 9/20/97 dh Certificate of Death . Decedent's Neme (First, Middle, Last) 2. Date of Deeth **Physician** SEPT. 05, Day 1997 Yeer Anthony DeFontes /Medical 4a. Facility Name (If not Institution, give street and number) **Examiner** 4630 SCHENELY RD. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 220-72-3926 7. Age (In yrs. last birthday) Funeral 18 M 2□ F Months Deys Hours Yrs Director 40 Usuai Residanca of Decedent the Marylend 10a. Stata 10c. City, Town or Location 10b. County 28a-f show r than "natural", or items 23a or 28s-f shov the Medical Examiner must be notified at MD. N/A Baltimore Director 10a Street and Number 10f. Zlp Code 8201 Melody Ln. 21208 Funeral deeth 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ②No If Yes, Giva Yeer or Dates: 11. Meritel Stetus filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify λq 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementery/Secondery (0-12) College (1-4or 5+) Musician +4 traumatic event, 17 Fether's Neme (First Middle Last) Be Pages 1 and 2 should be furnity of Health end Mental Family (18 marked of DeFontes Wayne King Lila 0 19a. Informent's Name/Relationship (Type, Print) Michael DeFontes/Brother 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 0 1 ☐ Burial 2 Cremetion 3 ☐ Ramoval from State Hilltop Service Co. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of F on each line **Physician** Immediate Cause (Final NARCOTIC INTOXICATION disease or condition resulting in death) Examiner Due to (or as a consequenca of):

4b. City, Town, or Location of Death 4c. County of Death BALTIMORE 8. Date of Birth (Month, Day, Year) Dec. 12 1956 9. Birthplace (State or Foreign Dec. Maryland 10d. Inside City Limits 1X Yes 2 No 10g. Citizen of What Country? USA Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Reca - American Indien, Black, White, etc. Specify: White 16b. Kind of Business/Industry Music 18. Mothar's Name (First, Middle, Malden Sumame) Smith Marie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8201 Melody Ln. Baltimore, Md. 21208 20c. Location - City or Town, State 9-8-97 Towson . MD . 22. Name and Address of Facility Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 at ceused the death. Do not enter the mode of dylng, such as cardiac or respiretory arrest, Approximete Intervei Between Onset and Daeth Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequance of) Dua to (or as a consequenca of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death?

and -tran physician the ding

Box 68760

P.O.

Division of Vital Records.

9

Examiner Inn/Medical ă Completed page Be 10 Medical Certification:

25. Was case referred to medical

examiner? 1XXes 2□ No

27. Manner of Death

2 Accident

3 Suicide

29a. Certitier

4 Homicide

1 Neturel

hes certificate

To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certified completely filled in by the funeral director.

State Registrar 29b. Signatura end title of certifler

5 Pending investigation

6XXCould not be datermined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

found:7:00^M

P

29c. License number O.C.M.E.

28c. Injury at Work?

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2X Medical Examiner: On the besis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) and manner stated.

1 Yes

2XX No

29d. Date signed (Month, Day, Year) SEPT. 06, 1997

28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4630 Schenely Road,

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yas

28d. Describe how injury occurred

Baltimore, Maryland

Other: 4 Nursing Home 5 Rasidence 8 Other (Specify)

unknown

26. Piece of Daath (Check only one)

2 No

24b. Were eutopsy findings eveilable prior to completion of cause of death?

1 Yes 2 No

3. Time of Deeth

7:23 PM.

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print)

Hospital:

28e. Dete of Injury (Month, Day Year)

found: 9/5/97

found: residence

HARLADURS A KOREL MM 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Dey, Yeer) SEP 1 0 1997

32. Registrer's Signeture ia Davidson

State of Maryland / Department of Health and Mental Hygiene 97 27395

| | | | | | | Certifica | ate of L | Death | | Reg. No. | f - 6m | 1000 |
|------------|--|----------------|---|---|------------------------------|-----------------|---------------------|------------------------------------|--|-------------------------------|-------------------------------|--------------------------------------|
| | Physic | | 1. Decedent's Name (First, Middle, La | ist) | | | | | 2. Date of D | | Year | 3. Time of Death |
| | /Medi | | Lo | cetta M. Du | vall-Mi | ller | | | SEMEM | BER 8 | 997 | 1:50 P.M. |
| | Exami | | 4a. Facility Name (If not institution, given | | | | 41 | b. City, Town, | or Location of Dea | th 4c. County | ot Death | |
| | | | | UDEL HO | | | G | IBNB | URNIE | ANNE | FARI | UNDEL |
| | Funeral | | | Gex 7. Age (1 ☐ M 2 □ F | (In yrs. last birth | Month | | If Under 24 H Hours M | in. (Month, D | rth ay, Year) | 9. Birthpla Countr | ace (State or Foreign |
| | Director | | 218-34-0992A Usual Residence of Decedent | | 80 Y | rs. | | | Aug.26 | ,1917 | Mary. | |
| | puel # | | 10a. State 10b. County | 1 | Oc. City, Town | or Location | | | | | 100 | d. Inside City Limits |
| | Mary | ō | Maryland Anne A | Arundel | | Glen | Burnie | 2 | | | | 1 ☐ Yes 2√2 No |
| | tha 288 | Director | 10e, Street and Number | | | | Zip Code | | | 10g. Citizen of V | What Countr | N? |
| | be filed within 72 hours aftar deeth with tha Maryland lal Hygiene. Id Hygiene. d other than "natural", or items 23s or 28s-f show event, the Medical Examinational to notified at | Ö | 1110 Castle Ha | rhor Mass 7 | Apt.2D | | 210 | 160 | | | | ,. |
| | tar deeth items 2 | Funeral | 11. Marital Status | 12. Was Decedent Ev | _ | 13. Was De | | | (Specify Yes or N erto Rican, etc.) | | S.A. e - American | n Indian, |
| 0 | r he | E | 1 Never Married 2☑ Married | Armed Forces? 1 ☐ Yes 2 📆 No | | | | | erto Rican, etc.) | | k, White, et | |
| 21215-0020 | 72 hours aff | by | 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give Year or Dates: | | 1 ☐ Yes | 2 🛛 No | Specify: | | Specify | . Whit | te |
| 5-0 | 72 hc | Completed | 15. Decedent's E (Specify only highest gro | ducetion | 16a. l | Decedent's U | sual Occupa | ition uning most of v | undrina | 16b. Kind of Bi | siness/Indu | ıstry |
| 21 | ithin | pldu | Elementary/Secondary (0-12) | College (1-4or 5+) | | life. DO NOT | Tuse retired) |) | VOINING | | | |
| | yojer trerth | S | 8 | N/A | | Own | | | | Duvall | | ٥. |
| nd | tal H d oth | Be | 17. Father's Name (First, Middle, Last |) | | | | 18. Mother's N | lame (First, Middle | , Ma <i>iden Sum</i> am | e) | |
| Yla | 2 should be filed within on the market other than Is market other than raumatic event, the Market t | 2 | Josep | | | | | | Livenia | | | |
| Maryland | ges 1 end 2 should be filed within 72 h. t of Haalth end Mental Hygiene. If Itam 27 Is marked other than "natuu or other traumatic event, tre Heolica. | | 19a. Informant's Name/Relationship (| | | | | | Rural Route Numi | | | |
| | faaltim 27 | | Shirley M. Schnei | | 20b. Place of | | | Beach R | oad Pasa | | * | the second second second |
| Baltimore, | permit. Pages 1 end 2 Department of Haalth of Important: If Itam 27 is eny Injury or other tra once. | | 20a. Method of Disposition 1208 urial 2 ☐ Cremation 3 ☐ | | cemetery | , crematory o | or other place | | Date | 20c. Locetion - | 12.012 | |
| tir | t. Pa rtmer rtant: sjury | | 4 □ Donation 5 □ Other (Specif | - | Cedar | | | | 12,1997 | Baltimo | re,Mai | cyland |
| Bal | permit. Page Department of Important: If eny Injury or once. | | 21. Signature of Funerel Service Lice | 12/ | 1, | Machal | and Address | | Funeral 1 | Home | | |
| | | | 23a Fárt1. Enter the disease, or com shock, or heart taiture. List only | 1 com | M | 3294 | Mounta | in Roa | d_Pasade | na. Mary | land_ | 21122 |
| | | | shock, or heart taiture. List only | plications that ceused th one cause on each tine. | e death. Do no | ot enter the m | node of dying | , such as card | lac or respiratory | arrest, | 1 | Approximate Interval Between |
|) | Physician /Medical | | Immediate Cause (Finel | 4 | | , | | | | | | Orisot and Death |
| | Examiner | Н | disease or condition resulting in death) | | PIRAT | | | | | | 1 | 134. |
| | | ē | | | e to (or as a co | - | , | | | | - | 70 dasa |
| | Detroit ansit | Examiner | | U. | GAC F | | | | | | 1 | natter |
| ć | axec in en ial-tr | Exa | if any, leading to immediate | | ie to (or as a co | | in ide | | | 6 | MasTI- | |
| 68760, | certificete be axecuted Iding physician end Ise as the burial-trensit | edical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or trijury that initiated events | V | e to (or as a co | _ | _ | 1cool e | | | | |
| | E 0 6 | Med | resulting in death) Last | | (| | | | | | | |
| Box | attendin | | | d | | | | | | | 1 | |
| | 0 0 0 | Physician/ | Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacc | | | | | | | | | the cause of death? |
| P.0 | to to | Phy | | | 1□ | Yes 2 No | 3 Probe | ably 4 🗆 Unknown | | | | |
| Ś | S C S | by | | | | | | | _ | | | |
| Records, | v requires been sign should be | sted | | | | | | | | an autopsy ormed? | avail | e autopsy findings lable prior to |
| ec | 2 S | npie | | | | | | | | | | pletion of cause eath? |
| H | F ag | Completed | | | | | | | 10 | Yes 2 No | 10 | Yes 20 No |
| Vital | ician: Th | Be | 25. Was case referred to medical examiner? | / | | | | 26. Place of D | eath (Check only | one) | | |
| 0. | 97 0 | 2 | 1 Yes 2 No | Hospital: | 2 ER/Outp | | | 4 Li Nursing | Home 5□ Res | | 1 1 7 7 | |
| | leath. | lo | 27. Manufer of Death 1 Natural 5 □ Pending | 28a. Date of Injury (Month, Day Y | <i>'ear)</i> 28b. Tir Inj | ury | 28c. Injury Work | | 28d. Describe | how injury occur | ed | |
| Sign | tand death tor: | icat | 2 Accident Investigation 3 Suicide 6 Could not b | | 411 | М | | 'es 2□No | 001.1 | | | |
| Division | or Attan efter des Director | Certification: | 4 ☐ Homicide determined | 28e. Place of Injury building, etc. (| - At home, fam Specify) | n, street, tact | lory, office | | City or To | Street and Numb wn, Stete) | ar or Hural F | Houte Number, |
| | Hospital 24 hours e Funeral I staly filled | | 29a, Certifier 1 Cartifying Ph | uniclem. To the heat of m | au kanuladan | danth accura | | | | | | |
| | To the Hospital or I within 24 hours efter To the Funeral Dire completely filled in b | edicai | | ysician: To the best of n niner: On the besis of ex and manner stated | amination and/ | or investigati | on, in my opi | e, date and ple inion, death oc | ce, end due to the curred at the time | date and place, | nner as stat and due to ti | he cause(s) |
| | within 2 To the comple | Me | 29b. Signature and title of certifier | arra marmor statos | | 2 | 29c. License | number | | 29d. Date signed | J (Month, Da | ay, Year) |
| | ->-0 | | Arata | 1 | MD | | N 42. | 977 | | C + . | D | × 1967 |
| | ^ | | 30. Name and address of person who | | | voe. Print) | 277 | 111 | | -epiems | E. MD. 21061 | |
| | 1 | | Compile Dreite | m/n: 301 | Homb is | AL 1 | RIVE | GEN | Dais . | M. FIL | D | 21061 |
| | Sta | ite | 31. Date tiled (Month, Dey, Year) | 3 Registrar's | Signature | , - | - | . 9 | ome | | | |
| | Registr | | SEP 1 0 1997 | guir Dav | dson-Ran | de M. | | | | | | |

| A EBONIN | 1 1 | t I,27 per MEO G- | | | | Cer | tificate | Oī | Dea | tn | 2. Date of D | Reg. No | | | 3. Time of Death |
|--|--------------------|---|-----------------------|---|-------------------|-------------------|---|-------------------------------------|----------------|------------------------------|-------------------------------------|-------------------|--|------------------------|--|
| Physician /Medical | ı | Nneka Chris | tine Eb | onin | е | | | | | | SEPTEM. | BER (| | 997 | 3:21 AM |
| Examiner | | e. Fecility Neme (If not institution 5020 GOODNOW R | | | | | | | | Town, or L | ocation of Dee | | | of Deeth | e City |
| Funeral Director | l | Sociel Security Number N/A | 6. Sex 1 ☐ M 2 🔏 I | 7. Age | e (In yrs. lest l | birthday) Yrs. | If Under 1 Months I | Yaar Deys 5 | If Und | der 24 Hrs. rs Min. | 8. Date of B (Month, L August | ley, Year) | | | |
| or 28=1 show or notified at Director | | Javal Residence of Decedent 10a. State 10b. Count 1aryland Balti | more City | , | 10c. City, To | timo | | | | | | | | | 10d. Inside City Limits 1 Yes 2 □ No |
| 23a or 28a-1 or 18a-1 | н | Oe. Street end Number 5020 Goodnow | Rd. Apt | . F | | | 10f. Zip C | | | | | 10g. Citizen of W | | | |
| urs after des al', or items Evarriner m by Funel | lo se Completed by | Marital Status Mary Merried 2 Ma Widowed 4 Divorce | 12. Wes D Armed | Ever in U,S. | | | nt of I | | | ecify Yes or No Rican, etc.) | | 14. Rac Blac | | ican Indien, , etc. | |
| ygiene. Ar than "natur At, the Medical Completed | | 15. Decade (Specify only higher Elementary/Secondary (0-12) | +) | 16e. Decadent's Usuel Occu (Give kind of work done life. DO NOT use retire Depende | | | | fone during most of working etired) | | | Not Self Suppo | | STATE OF | | |
| h and Mantal Hygiene. 7 Is marked other than traumatic event, the Me | | 7. Father's Neme (First, Middle Andrew I. E | | 18. Mother's Name (First, Middle, Maiden Su Pauline Eziam | | | | | | Sumer | | appor cing | | | |
| item 27 is me other traums | | Andrew I. Ebonine 199. Informent's Name/Reletionship (Type, Print) Mr. Andrew I. Ebonine / Father | | | | | 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip 5020 Goodnow Road Apt. F Baltimore, M | | | | | | | | |
| | | 0a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donetion 5 □ Other (3 | | | | | | | , | Sept. | Date 12,199 | | | City or T | own, Stete MD |
| Department Important: Hany Injury o | | 21. Signature of Funerel Service Michael C | Licansae Mich | ael E. | . Canapp | | Name end A | | | 1 | eonard Baltim | | | | c. 214 |
| Physician /Medical Examiner | | 23e. Part1. Enter the disease, c shock, or heart feilure. Lis immediete Ceuse (Finel disease or condition resulting in death) | the deeth. Do | T DEAT | H SYNDI | | | | or respiretory | errest, | | | Approximete Intervel Between Onsat and Deeth | | |

as that the death certificate be exec id be detached for use as the buriel-tra signed by

Physician/Medical Completed by Be Medical Certification: To

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physitin 24 hours after death.

To the Funeral Director: After this filled in by the funeral

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Exa

Due to (or as e consequence of): Due to (or es e consequenca of):

Part II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I.

24a. Wes en eutopsy performed?

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 2 No

Unknown

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably

25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1XX es 2 □ No 1 Inpatient 2 ER/Outpetient 3 DOA 28c. Injury at Work? 28d. Describe how Injury occurred 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of

XX Natural 5 Pending Investigation Injury 1 Yes 2 🗆 No 2 Accident 6 Could not be determined 3 Suicide 4 - Homicide

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

SEPTEMBER 09,1997

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the causa(s) and manner as steted.

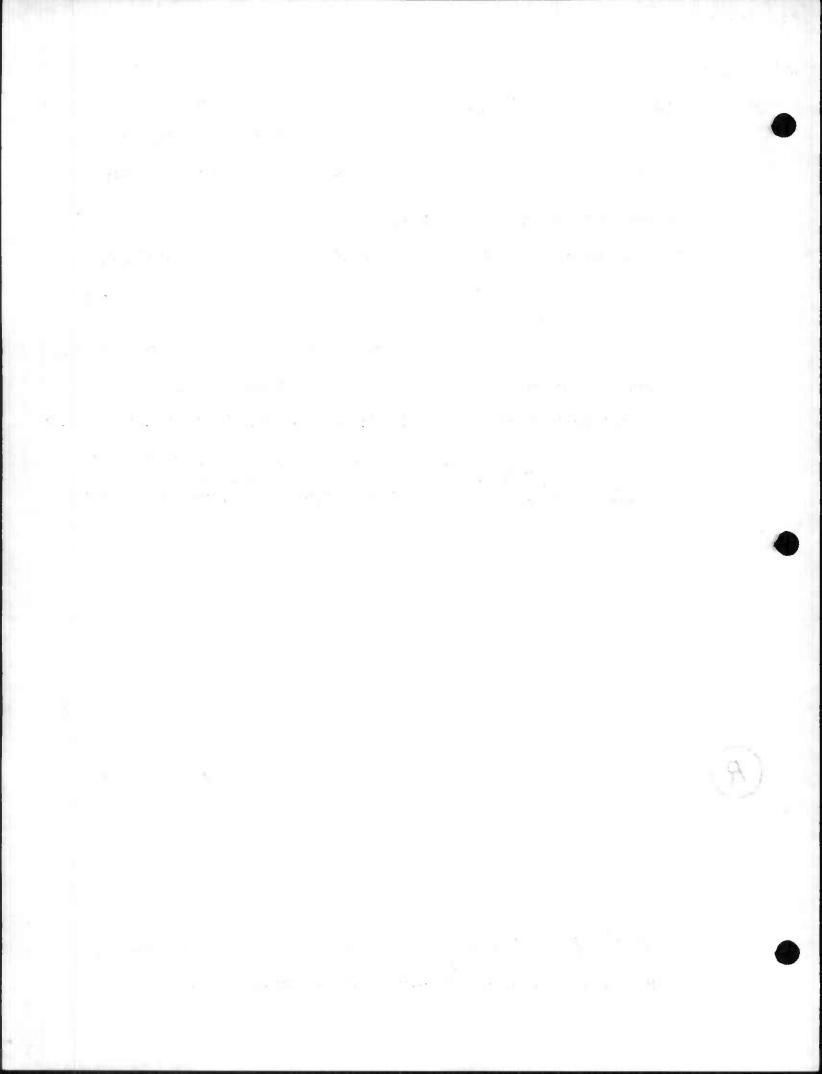
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the causa(s) end menner stated. 29b. Signatura and title of certifian 29c. Licanse number 29d. Data signed (Month, Dey, Year)

30. Neme end eddress of person who completed cause of deet tem 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

State Registrar 32. Registrar's Signature



WRC 97-5091-031 FOUNTAIN D.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0.7

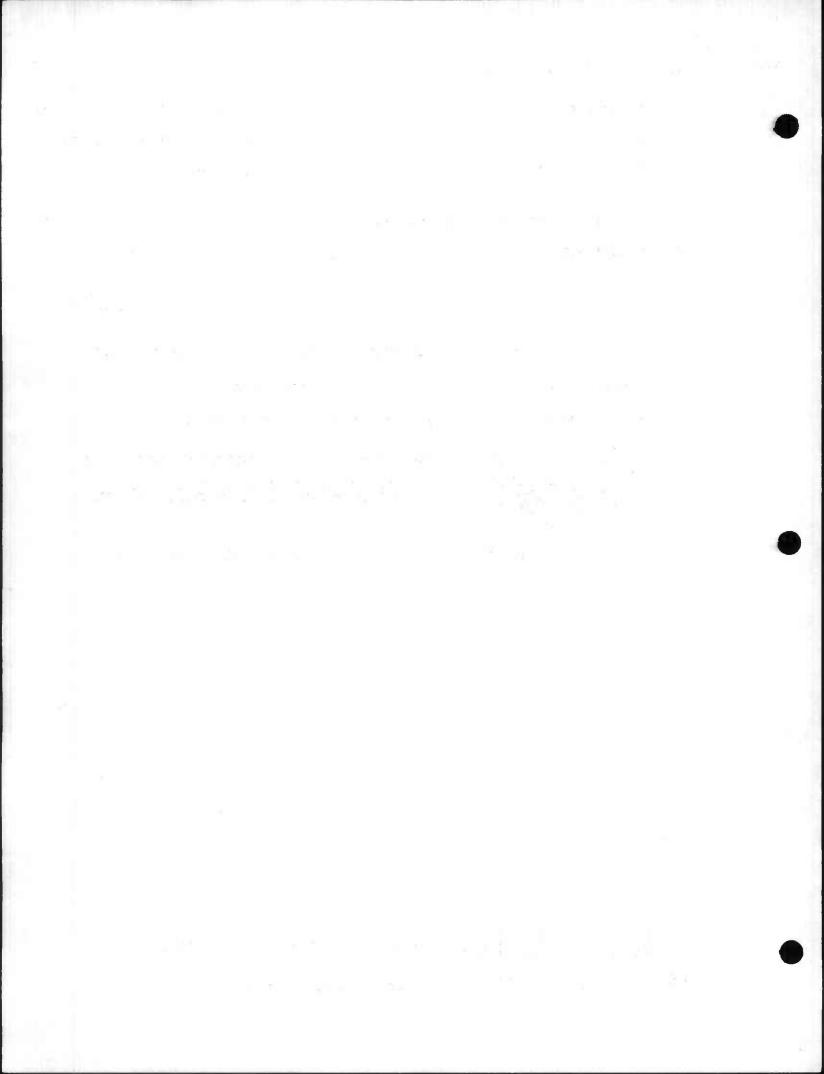
| AVID | | ITEM: 5,14 per F.I | | ∪ - 9/ e | on | Ce | rtificat | e or i | Deam | 2 | Dete of De | Reg. No. | | 3. Time of Death |
|---|----------------|---|--|--|------------------------|--|---|-------------------------------------|--|--|--------------------------------------|----------------------------------|--|---|
| Physic | ian | | | | | | | | | | Month | Day | Year | |
| /Med Exami | | DAVID FOUNTA 4a. Facility Name (If not institut | | number) | | | | 4 | b. City, Town | | | 06, 199 | ty of Deeth | 4:50 PM. |
| LAGIII | iici | 7417 CARROLL | AVE. | | | | | - | TAKOMA | PARK | | | | EORGES |
| Funeral Director | | 5. Social Security Number UNKNOWN 049-58-8046 | 6. Sex 1 → M 2 □ I | 7. Age | 37 | lest birthdey Yrs. | Months | | If Under 24 | | Date of Bird (Month, Da 2/19/1 | h y, <i>Year</i>) L959 | 9. Birth Cou CT | nplace (Stete or Foreig intry) |
| /and | | Usual Residence of Decedent 10a. State 10b. Coun | ty | | 10c. Cit | y, Town or L | ocation | | | | | | | 10d. Inside City Limit |
| n the Maryland r 28a-f show | Director | MD PRIN | CE GEORGE | S | TA | KOMA I | PARK | | | | | | 1 ☐ Yes 2 ☐ | |
| death with the Maryland ms 23a or 28a-f show | i Dire | 10e. Street and Number 7417 CARROLL A | VE. | | | | 10f. Zip | Code 209 | 12 | | | 10g. Citizen of U | What Cou | |
| al yidilid X.1X.13-00X0 should be filed within 72 hours after death nd Mental Hygiene. I marked other than "natural", or ftama 2 umatic event, to Marical Exercises in | by Funeral | 11. Marital Status 1 Never Married 2 M. 3 Widowed 4 Divorci | arried 1 TYes, | Forces? | | ,S. 13. | Was Deced If Yes, spec | | ispanic Origin In, Mexican, P Specify: | ? (Specify uerto Rica | Yes or No an, etc.) | | Raca - American Indian, Black, White, etc. ecity: WHITE BLACK | |
| nin 72 hou | Completed | (Specify only high | ent's Education | | | 16a. Dece (Give life. | dent's Usua kind of wor DO NOT us | al Occup rk done i se retired | ation during most of | working | | 16b. Kind of I | | |
| od with | Com | Elementary/Secondary (0-12 | 3 | e (1-4or 5 | +) | ASSIS | TANT | MANA | GER | | RADIO SHAG | | | CK |
| Mid y Idillo Z. I | To Be | 17. Father's Name (First, Middle PAUL FOUNTAIN | | Oriest 405 Mayres | | | | | | Name (First, Middle, Maiden S MCSWAIN | | | me) | |
| | | 19a. Informant's Name/Relatio LELA FOUNTAIN | | | | | | | end Number of GREEN | | | or, City or Town | n, Stete, Z | ip Code) |
| of Hee | | 20a. Method of Disposition 1 ☐ Burial 2 🕱 Cremation | 3 Pamayal fra | m State | 20b. F | Place of Disperent | osition (Nem | ne of ther plea | :e) | - | ate | 20c. Location | - City or 7 | own, State |
| tment tant: I | | 4 Donation 5 Other | (Specify) | | CH | ESAPEA | | | | | | | | , MD |
| permit. Pagas 1 and 2 Department of Health s Important: If item 27 is any injury or other tra | | 21. Signatur of Funeral Service | e Licensee | 22. Name and Address of Facility STERLING ASHTON 736 EDMONDSON AV that caused the death. Do not enter the mode of dying, such as ca | | | | | | | | | | 21228 |
| | | 23a. Panti. Enter the disease, shock, or heart failure. Li | or complinations the st only | at caused on each lin | the deat e. | h. Do not en | ter the mode | e of dyin | g, such es car | diec or re | spiratory a | rest, | | Approximete Interval Between Onset and Death |
| /Medical Examiner | Г | Immediate Cause (Final disease or condition | Hy | (Can | मर | الارن | HTA | ons | SCUETUO | nc (| DOD | OVASU | um | |
| | ner | resulting in death) | | | Due to (d | r as a conse | quence of): | | | TIC CAMPIOVASCUM DISEDSE | | | | |
| ficate be executed g physician and as the burial-transit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | 6 | [| Due to (c | r as a conse | quence of): | | | | | | | |
| ata be hysicia the bu | edical | Cause (Disease or injury that initiated events resulting in death) Last | Due to (o | r as e conse | quence of): | | | | | | | | | |
| E 016 | _ | | | | | | | | | _ | | | | |
| ine death cert | Physician/M | Part II. Other significant condi | tiona contributing to | death bu | t not res | ulting In the u | ınderivina cı | ause giv | en in Part I. | | 23b. Dld 1 | obacco use c | ontributa | to the cause of death |
| rice for the tracked for 2 should be detached for | by Phy | | | | | | | 1 🗆 | Yes 2□ No | 3□ Pr | obably 4 Onknow | | | |
| | Completed b | | | | | | | | | | performed? ava | | | Vere autopsy findings valiable prior to ompletion of cause if death? |
| The sate to page | Com | | | | | | | | | | 16 | res 2□No | 1 | Yes 2 No |
| sician: The certificate irector, pag | Be | 25. Was case referred to medic examiner? | Hospital: | | | | | Oth | | Death (C | (Check only one) | | | |
| Phys r this aral di | To To | 1 Yes 2 No 27. Manner of Death | 28a. Da | te of Injur | 4 | ER/Outpatie 28b. Time of | | _ | 4 LI NUISII | - | | denca 6 □O | | ify) |
| Attending Physician: The probability of the fundation of | cation | E C / teoridoria | tlgation | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | | | | | | | | | | |
| To the Hospital or Attanding Physicians: within 24 hours after death. To the Funeral Director: After this certific complataly filled in by the funeral director. | Certification: | 3 Suicide 6 Coul 4 Homicide deter | mined 288 Pla | ace of Inju ilding, etc. | ry - At ho (Specify | ome, farm, st | reet, factory | , office | | 28f. | Location (S City or Tox | Street end Num yn, Stete) | ber or Ru | rel Route Number, |
| To the Hospital or within 24 hours afte To the Funeral Dir completely filled in | edical | 29a. Certifier 1☐ Cartify (Check only one) 1☐ Cartify | ing Physician: To the Examiner: On the and m | the best of basis of anner stat | examina | wledge, deat tion and/or In | h occurred a | in my o | ne, date and p pinion, death o | ace, and occurred a | due to the | cause(s) and n date and place | nanner as , and due | stated. to the causa(s) |
| within 2 To the compla | Me | 29b. Signifure and title of certif | 1410.75 | 0/ | | | 29c | . Licens | number | | | 29d. Dete sign | ed (Month | , Dey, Yeer) |
| | | WOUNTE | HW | 29c. License number O.C.M.E. | | | | SEPT. 07, 1997 | | | 1997 | | | |

State Registrar 31. Date filed (Month, Dey, Year) SEP 1 0 1997

111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Hilda September 8, 1997

4b. City, Town, or Location of Death

4c. County of Death Fisher /Medical 4a. Facility Name (If not institution, giva street and number) Examiner Baltim ore
If Under 24 Hrs. 8. Data
Hours Min. (Mor Hospital 5. Social Security Number If Under 1 Yaar 6 Sex 8. Data of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funerai** 1 M 2 KF Months Days 215-28-5729 Director Usual Residence of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits other treumatic event, the Medical Examiner must be notified at Baltimore Director 1 Vas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò atayette 1 12. Was Decedent Ever in U.S. Armed Forcas? Rema 23a 25 U. S.A Funeral Was Decedent of Hispanic Origin? (Spacify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - Amarican Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yas 2 10 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 ò 1 Yes 2 No Black þ 3 Widowed 4 Divorced permit. Pagas 1 and 2 should be filed within 72 hours
Department of Health and Mentel Hygiene.
Important: If item 27 is marked other than "natural",
any injury or other treumatic event Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Private Home Etementery/Secondary (0-12) College (1-4or 5+) thgrade Domestic Worker 17 Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Kichava +lowers Tar riet 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Maisel 7 sher 21230 Ma 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21215 4300 u lade red 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Wabash 140 Avenue Approximate Intervel Between Onset and Deeth **Physician** immediate Cause (Final disaase or condition resulting in death) /Medical Examiner Examiner that the deeth certificate be executed physician and is the bunal-trans Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseasa or Injury that Initioted events resulting In death) Last Box 68760 sease Physician/Medical Dua to (or as a consequence of). P.O. 1 ed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceusa given in Part i. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably Cunknown 1 Yee 2 No þ Records Completed 24b. Were autopsy findings available prior to 24e. Was an autopsy performed? completion of ceuse of death? 2 0 No 1 Yes 1 Yes 2 No Division of Vital or Attending Physicien: Be 25. Wes case referred to medicel examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 70 2 ER/Outpatient 3 DOA 1 Inpatient 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death

1. Naturat

2. Accident 28a. Date of Injury (Month, Day Year) Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Invastigation 24 hours after death. 1 Yes 2 No 6 Could not be determined 3 Sulcide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Straet and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the To the To the F

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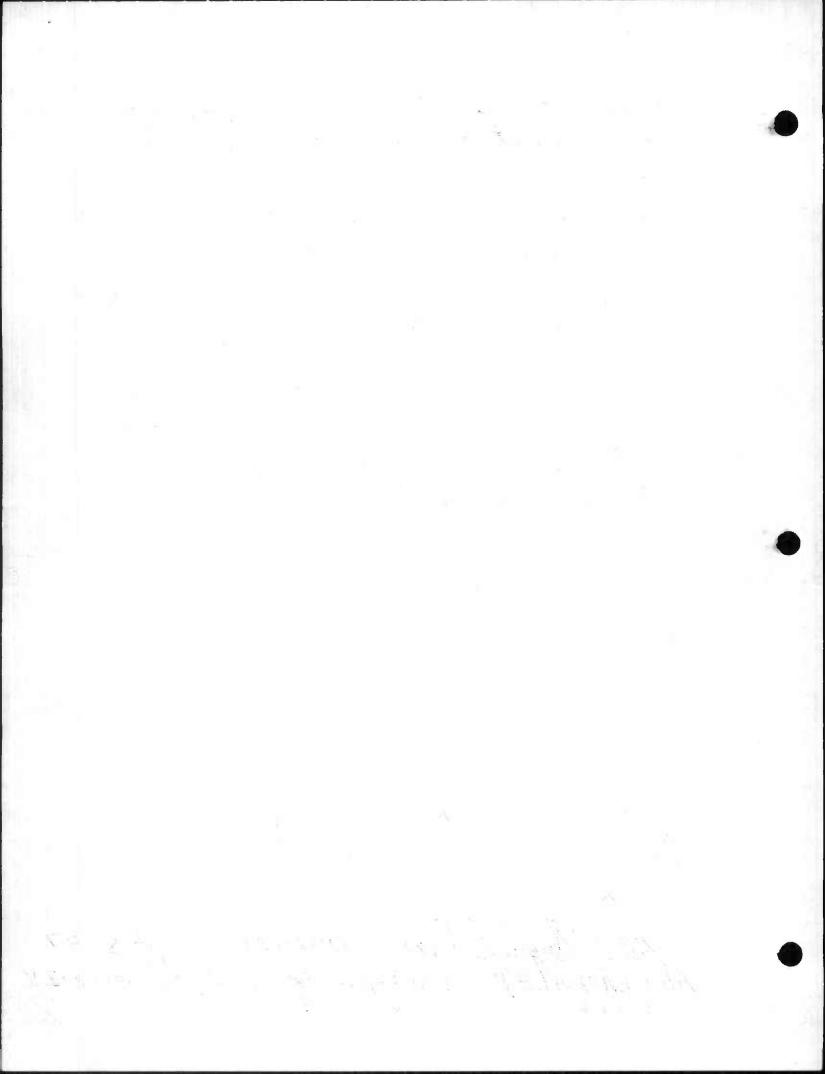
grove St. Bat. MD 21216

State Registrar

29b. Signature and title of certifier

he and address of person who co

moteted cause of death (Item 23a) (Type



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** 2°3,1997 Lawrence Frank September 1:42 pm Jr. /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth Examiner 4c. County of Deeth City Johns Hopkins Bayview Medical Center Baltimore If Under 24 Hrs. 5. Sociel Security Number If Under 1 Year 8. Date of Birth (Month, Dey, Year) July 13, 1920 7. Age (In yrs. lest birthday) **Funeral** Birthplece (State or Foreign Country) Min. Hours ìQM 2□F Director 216-12-3967 Maryland Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2□ No Director Md. N/A Baltimore 10e. Street end Number 10f. Zin Code 10g. Citizen of Whet Country? 617 S. Clinton Street 21224 U.S.A. death Funeral 12. Was Decedent Ever In U,S. Armed Forces? NET Yes 2 □ No If Yes, Give Year or Dates: '↓ ↓ □ ↓ ↓ ↓ 14. Raca - American Indian, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Merital Status 2 should be filed within 72 hours efter in end Mentel Hygiene. Is marked other than "natural", or its 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Š Specify: 3√2 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry Elementery/Secondary (0-12) College (1-4or 5+) Asst. General Manager Dept. Public Works 12 permit. Peges 1 and 2 should be file Department of Health and Mentel Hy, important: if fem 27 is marked othe any Injury or other traumatic event, once. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Lawrence C. Frank, Sr. Elizabeth A. Buettner 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Suzan Smith/Daughter 8257 Bullneck Road, Balto., Md. 21222 20b. Placa of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremetion 3 Removel from Stete 9/6/97 Sacred Heart of Jesus Baltimore, Md. 21. Signeture of Funeral Service Licenses 22. Name end Address of Fedility 21224 2 Charles S. Zeiler & Son, Inc. 6224 Eastern Ave. 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximate Intervel Between Onset end Deeth **Physician** Immediete Ceuse (Finel disease or condition resulting in deeth) /Medical e Coronary Artery Disease 6 years Examiner Due to (or es e consequença of): Physician/Medical Examiner Chronic Obstructive Pulmonary Disease 2 years physician and the burial-transit net the deeth certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760, Due to (or es e consequença of) 98 ed by the e Pert II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown ģ 8 Completed 24e. Wes en eutopsy performed? 24b. Were sutopsy findings eveilable prior to completion of cause of deeth? page certificate 1 TYes 2 No 1 Yes 2 No Division of Vital or Attending Physician: director. Be 25. Wes case referred to medical exeminer? 26. Plece of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpetient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 3D DOA funeral 27. Menner of Deeth Certification: 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Netural death. 1 ☐ Yes 2 ☐ No the 2 Accident ofter death 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) filled In by 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end manner es stated.

2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred et the time, date end plece, end due to the cause(s) end menner stated. 29e. Certifier Medical completely (Check only onel To the To the I 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) September 4, 1997 nd eddreys of person who completed cause of deeth (Item 23e) (Type, Print) Johns Hopkins Bayview Medical Center Jocelyn -Sayed, MD 4940 Eastern Avenue, Baltimore, MD 31. Dete filed (Month, Day,

DHMH 16 Rev 6/95

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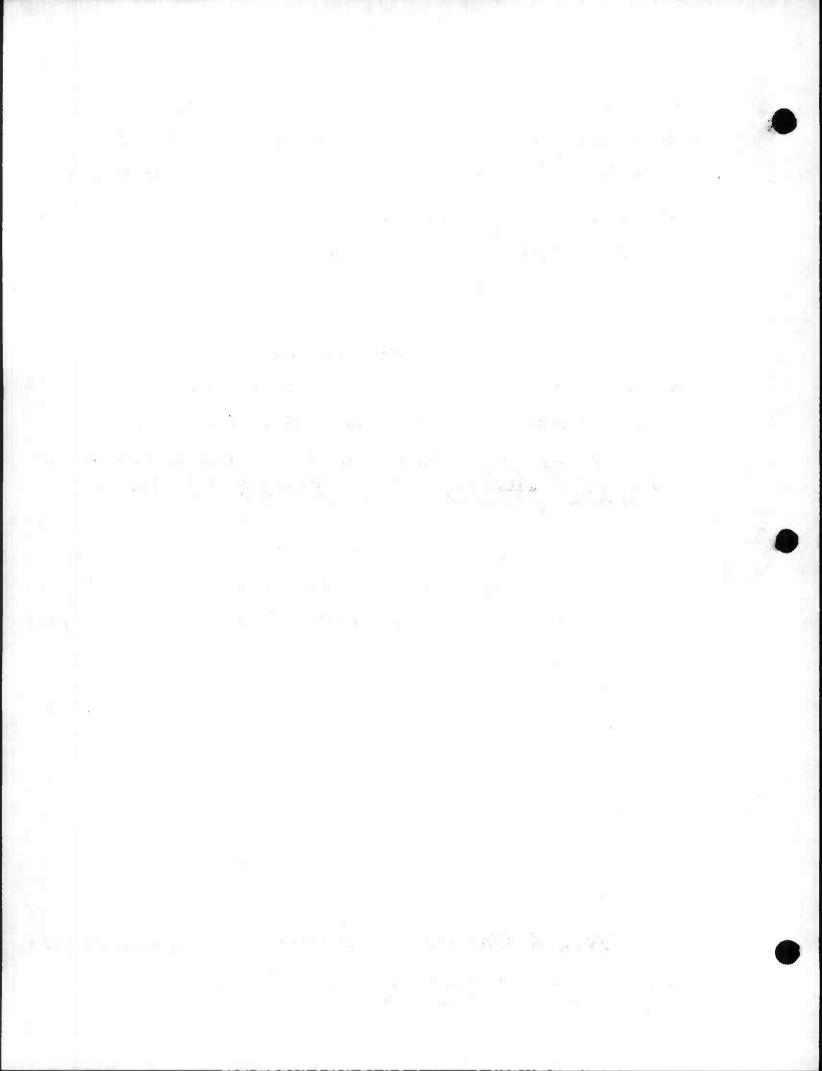
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| | | | State of Maryland | | ficate of | | | Reg. No. | 1 6 | 2/400 | | | | | |
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| | Dhuala | lan | Decedent's Neme (First, Middle, Last) | | | | 2. Dete of D Month | eeth Dey | Year | 3. Time of Deeth | | | | | |
| | Physic /Medi | | DOROTHY SALVADOR | E F | ONTZ | | SEPTE | | | 04:40A1 | | | | | |
| | Exami | | 4a. Fecility Neme (If not institution, give street end number) | | | 4b. City, Town, or I | ocation of Dee | th 4c. Cour | nty of Deeth | | | | | | |
| | | | HARBOR HOSPITAL CENTER | 2 | | BALTI | MORE | | n/a | | | | | | |
| | Funeral Director | | 5. Sociel Security Number 6. Sex 1 ☐ M 2☐ F 70 | | If Under 1 Yeer Months Deys | If Under 24 Hrs. Hours Min. | 8. Date of Bi (Month, D Feb. 8 | rth ey, <i>Year)</i> 3 1927 | | plece (State or Foreign http:) 1and | | | | | |
| | pus * | | Usuel Residence of Decedent 10a. State 10b. County 10c. City. | , Town or Locat | lion | | | | 1. | IOd Incide City Limits | | | | | |
| | Sa-f sho | ctor | Md. n/a Ba | altimore | | | | | | 10d. Inside City Limits 1 1 Yes 2 No | | | | | |
| | 23a or 2 | Funeral Director | 600 Light Street Apt. 823 | | 10f. Zip Code | 21230 | | 10g. Citizen d | of Whet Cour SA | itry? | | | | | |
| 21215-0020 | permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, tra Modical Examiner must be notified at once. | by | 11. Maritel Status 1 □ Never Merried 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Wes Decedent Ever in U,S Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Detes: | | | Hispenic Orlgin? (Sen, Mexican, Puert Specify: | pecify Yes or N o Rican, etc.) | | lece - Americ leck, White, city: Whi | etc. | | | | | |
| 5-0 | 72 h netu | Completed | 15. Decedent's Education (Specify only highest grade completed) | 16e. Deceden | t's Usuel Occup | petion during most of wor | kina | 16b. Kind of | of Business/industry | | | | | | |
| 21 | ithin ithin | npje | Elementery/Secondery (0-12) College (1-4or 5+) | | | during most of word) | Kirig | | | | | | | | |
| 7 | ygier f. It | ပို | 6 0 | House | ewife | | | | Owner | | | | | | |
| n | d off | Be | 17. Father's Name (First, Middle, Last) | | | 18. Mother's Ner | | | meme) | | | | | | |
| Yla | should nd Men marks umatic | 2 | | ī | | • | | | | | | | | | |
| Maryland | 2 sh and Is m | | | | | | | | | | | | | | |
| | 1 and Health em 27 | | | | | · · · · · · · · · · · · · · · · · · · | | | | | | | | | |
| Baltimore, | Peges I ment of H ant: If ite ury or ot | | 1 M Buriol 2 Commetter 2 D Barrowston Ctata Ca | metery, cremete | ory or other ple | ial Pk. | Sept 9 1997 | | 1 | | | | | | |
| Ball | permit. I Departm Importar any Injui | | Joseph Marsiglia 19a. Informent's Neme/Reletionship (Type, Print) Josephine E. Fontz (Daughter) 919 Catawlia Court, Baltimore, Md. 21 20a. Method of Disposition 1 | | | | | | | | | | | | |
| | 100 | | 23e. Pert1. Enter the disease, or complications that caused the deeth. | | | | | | 1 | Approximete Interval Between | | | | | |
| Я | Physician | | Action Crosses Action 2 | | | | | | 1 | Onset end Death | | | | | |
| | /Medical Examiner | | Immediate Cause (Finel disease or condition recuting in death) | TED F | DEPTIC | ULCEI | 2 | | | 7 DAYS | | | | | |
| | LAGIIIIIGI | L | 1050iting in doutin | es e consequer | | | | | Ī | 1_0,10 | | | | | |
| | pg iii | Examiner | - RESPIRATI | DRY F | FAILUR | E | | | | 5 DAYS | | | | | |
| | end -tran | хап | | | | | | | | | | | | | |
| 68760, | rificate be executed ng physician end es the burial-transit | | | | | | | | | | | | | | |
| 87 | ohysi the t | dice | ceuse (Disease or Injury the initiated events resulting in deeth) Lesl | | | | | | | | | | | | |
| _ | 5 00 | by Physician/Medical | d CHRONIC | OBSTE | RUCTI | VE LU | NEI D | ISEASI | E | 10YEARS | | | | | |
| Box | that the death cert ed by the ettendin detached for use | ian | | | | | | | | | | | | | |
| P.O. | the de | ysic | Pert II. Other significant conditions contributing to death but not result | ing in the unde | orlying cause give | en in Pert I. | 23b. Dld | tobacco use | contribute to | o the cause of death? | | | | | |
| | that the dead by the e | 표 | LARGE VENTRAL HERN | JIA | | | 1 🗆 | Yes 2 IN | 3 □ Prol | bably 4 Unknown | | | | | |
| Sping! | been signed should be def | | | 4-7-3 | | | 24a. Wei | s en eutopsy ormed? | ave | ere eutopsy findings eileble prior to | | | | | |
| Rec | Physician: The Liver to this certificate has be said director, page 2 s | Completed | | | | | 1 🗆 | Yes 200M6 | | mpletion of cause deeth? | | | | | |
| /ita | clan; ertific ector, | Be | 25. Wes case referred to medical examiner? | | | 26. Plece of Dee | th (Check only | one) | | | | | | | |
| - | hysic his c | 2 | | R/OutpatienI | 3□ DOA Oth | 4 LI Nuising H | ome 5 Res | | | y) | | | | | |
| Division of Vital | Attending Physician: or death. ector: After this certific by the funeral director. | :uo | 27. Menner of Deeth 28e. Dete of Injury 1 Neturel 5 Pending (Month, Dey Year) | 28b. Time of Injury | 28c. Injui Wo | | 28d. Describe | how Injury occ | urred | | | | | | |
| Sio | death. ctor: A y the fu | cati | 2 Accident investigation | | | Yes 2 □ No | | | | | | | | | |
| 2 | al or Attending P safter death. I Director: After t d in by the funera | Certification: | 4 Homicide determined 28e. Place of Injury - At hom building, etc. (Specify) | ne, farm, street, | , fectory, office | | | (Street end Nur wn, Stete) | nber or Rura | al Route Number, | | | | | |
| | ral Delli | Ce | 29a, Certifier 15 Certifying Physician: To the best of my know | | | | | | | | | | | | |
| | To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by | edicai | menner es st e, end due to | teted. o the cause(s) | | | | | | | | | | | |
| | Vott Vott | M | 296. Signature and file of certifier RESIDENT | 29d. Date sign | ned (Month, | Dey, Year) | | | | | | | | | |
| 1 | | | HARBOR HOSPITA | L CENTE | R 2L | 141,1614 A-1 SECTION | | | MAFR | 07,1997 | | | | | |
| , | 4 | | 30. Name end eddress of person who completed cause of deeth (Item | 23e) (Type Pris | nt) | ,,,,, | 2001 | S. HA | NOVE | R STREET | | | | | |
| | 0 | | 30. Name end eddress of person who completed cause of deeth (Item: SHARIF CHCWDHURY: HARBOR | itosp | TAL C | ENTER | RAITH | RE N | 0 2 | 1295 | | | | | |
| | Sta | | 31. Dete filed (Month, Day, Yeer) SEP 1 0 1997 Julie Sundson-As | иге | Annual State of the State of th | | y , . | 3 | | | | | | | |
| | Registr | | SEP I U 1997 grane favidon-Ro | indelle | | | | | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene 97 27401

| December 1 December Decembe | 1401 | | Reg. No. | | Death | ificate of | Cei | | | | | | | | | | |
|--|---|---|--|---------------------|--|--------------------------------|---------------------------|----------------------------|---|--|--|--|--|----------|--|--|--|
| Stromber 46. Clay Name first institution, pive street and number 30.01 HLLSAddae County Death 46. Clay Town, of Location of Death 46. Clay Town, of Location of Death 46. Clay Town, of Location of Death 46. Clay Town, of Location 46. Clay Town, of Location 46. Clay Town, of Location 46. Clay Town of Location 4 | 3. Time of Death | 1: | . Date of Death | 1 | | | | | st) | ne (First, Middle, La | 1. Decedent's Neme | | | | | | |
| Examiner As Pally Name (Incord Institution, pies steet and number) As Copy Town, of Location of Death As Copy Town, of Location of Death As Copy Town, of Location of Death As Copy Town, of Location of Death As Copy Town, of Location of Death As Copy Town, of Location of Death As Copy Town, of Location As Copy Town of Location As Copy Town of Location As Copy Town of Location As Copy Town of Location As Copy Town of Location As Copy Town of Location Location As Copy Town of Location Locat | 9:25 p.n | 1997 Year | Sept. 5, | | | | | | | GOVER JR. | JOHN W. (| | | | | | |
| Social South Number County | | | | , or Loca | b. City, Town, | | | mber) | e street and nu | If not institution, giv | 4a. Facility Neme (II | | | | | | |
| 214-38-5158 XM x CIF 57 Yr. | | Harford | Ho | on | Abingdo | | | | wrt | esdale Co | 3001 Hill | | | | | | |
| 100 Color 100 | | 9. Birthplac Country 1940 Maryl | Date of Birth (Month, Dey, Year) Wly 24, 19 | Min. | | | | | | 158 | 214-38-51 | | | 3 | | | |
| John W. Govet St. 19a. Informant's Name/Relationship (Type, Print) The Res a Govet (Wide) 20a. Method of Disposition 1 Burnal 2 Richempton 3 Removal frogr State 4 Donation, 5 Print (Symbol) 20b. Place of Disposition (Name of Carried Print) 20c. Location - City or Town, Stete, 2p. Co. 20c. Method of Disposition 1 Burnal 2 Richempton 3 Removal frogr State 4 Donation, 5 Print (Symbol) 21. Signature of Carried Print (Symbol) 22. Name and Address (Street and Number or Rural Route Number; City or Town, Stete, 2p. Co. 20c. Location - City or Town | Inside City Limits | 10d | | | | ation | ty, Town or Lo | 10c. C | | | | | 8 m | | | | |
| John W. Govet St. 19a. Informant's Name/Relationship (Type, Print) The Res a Govet (Wide) 20a. Method of Disposition 1 Burnal 2 Richempton 3 Removal frogr State 4 Donation, 5 Print (Symbol) 20b. Place of Disposition (Name of Carried Print) 20c. Location - City or Town, Stete, 2p. Co. 20c. Method of Disposition 1 Burnal 2 Richempton 3 Removal frogr State 4 Donation, 5 Print (Symbol) 21. Signature of Carried Print (Symbol) 22. Name and Address (Street and Number or Rural Route Number; City or Town, Stete, 2p. Co. 20c. Location - City or Town | 1 ☐ Yes 2 🕱 No | | | | | 101 71 0 1 | bingdor | A | | | - | ector | 28a-f sh | | | | |
| John W. Gover St. 19a. Informant's Name-Relationship (Type, Print) The Less Gover (Wise) 20a. Memod of Disposition 1 Dunial 2 (Coremption 3 Removal from State 4 Donaton 5 Print) 20b. Place of Disposition 1 Dunial 2 (Coremption 3 Removal from State 4 Donaton 5 Print) 21. Signature of Visual State 4 Dunial 2 (Coremption 3 Removal from State 4 Dunial 2 (Coremption 3 Removal from State 4 Dunial 2 (Coremption 3 Removal from State 4 Dunial 2 (Coremption 3 Removal from State 4 Dunial 2 (Coremption 3 Removal from State 4 Dunial 2 (Coremption 3 Removal from State 4 Dunial 2 (Coremption 3 Removal from State 4 Dunial 2 (Coremption 3 Removal from State 4 Dunial 2 (Coremption 3 Removal from State 4 Dunial State 5 Dunial State 5 | | .S.A. | u.s | | | 21009 | | | | | 3001 Hill | rai Dir | 23a or | | | | |
| John W. Gover St. 198. Informant's Name-Relationship (Type, Print) The Acad Gover (Wide) 200. Method of Disposition 1 Buriel 2 (Comption 3 Perint) 198. Method of Disposition 1 Buriel 2 (Comption 3 Perint) 200. Detail of Disposition 1 Buriel 2 (Comption 3 Perint) 201. Detail of Disposition 1 Buriel 2 (Comption 3 Perint) 202. Detail of Disposition 1 Buriel 2 (Comption 3 Perint) 203. Detail of Disposition 1 Buriel 2 (Comption 3 Perint) 204. Detail of Disposition 1 Buriel 2 (Comption 3 Perint) 205. Place of Disposition (Name of carried Print) 206. Place of Disposition (Name of carried Print) 207. Place of Disposition (Name of carried Print) 208. Place of Disposition (Name of carried Print) 208. Place of Disposition (Name of carried Print) 209. Place of Disposition (Name of carried Print) 209. Place of Disposition (Name of carried Print) 209. Place of Disposition (Name of carried Print) 209. Place of Disposition (Name of carried Print) 209. Place of Disposition (Name of carried Print) 209. Place of Disposition (Name of carried Print) 209. Place of Disposition (Name of carried Print) 209. Place of Disposition (Name of Carried Print) 209. Place of Disposition (Name of Carried Print) 209. Place of Disposition (Name of Carried Print) 209. Place of Disposition (Name of Carried Print) 209. Place of Disposition (Name of Carried Print) 209. Place of Disposition (Name of Carried Print) 209. Place of Disposition (Name of Carried Print) 209. Place of Disposition (Name of Carried Print) 209. Place of Disposition (Name of Carried Print) 209. Place of Disposition (Name of Carried Print) 209. Place of Disposition (Name of Carried Print) 209. Place of Disposition (Name of Carried Print) 209. Place of Disposition (Name of Carried Print) 209. Place of Disposition (Name of Carried Print) 209. Place of Disposition (Name of Carried Print) 209. Place of Disposition (Name of Carried Print) 209. Place of Disposition (Name of Carried Print) 209. Place of Disposition (| | Bleck, White, etc | fy Yes or No- can, etc.) | ? (Spec uerto Ri | | | | orces? 2 X No ve | Armed Fo 1 ☐ Yes It Yes, Gir | | 1 Never Marrie | by | ral', or item Examiner | 020 | | | |
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| 23a. Fart1. Entite the disease, or commisciflors that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, beautiful to the disease or commisciflors that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, beautiful to the disease or condition. Application of the disease or condition are suiting in death) Due to (or as a consequence of): | laryland | altimore. M | 10/97 Bau | 9/ | tory | itory or other ple it Cremo | cemetery, crer CEN MOU | State | 1 | Cremation 3 - | 1 Burial 2 Donation | | intment of intmant: If its injury or o | Itimor | | | |
| Physician Medical Examiner Part Discourse Disco | 14 | l Air, Inc. ir, MD. 210 | me of Bel, Bel Ai | l Ho Road | Funeral Phail R | umunek O W. Mac | \$ 6 i | 5 | til | ha | 1/ 1/2 | | med de de de de de de de de de de de de d | | | | |
| Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): VENTRICULAR TACHYCARDIA Sequentially list conditions, if any, leading to immediate a consequence of): Conjection of the conditions of the conditi | oproximate terval Between nset and Death | In | espiratory arrest, | diac or | g, such es card | the mode of dyl | th. Do not ent | aused the dee ech line. | fications that c oné cause <i>on</i> e | he disease, or comp rt failure. List only | 23a. Part Enter the abovek, or hear | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Enter Underl | 7 years | | PATHI | DI | 1:, I | A THO | MY () | ARDIO Due to (| . C | (Final n | disease or condition | | /Medical | | | | |
| Sequentially list conditions, and an autopsy performed? 24a. Was an autopsy performed? 24b. Were evalenced to medical exeminer? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 2 No 2 No 3 No | 74 ears | - | RDIA | 1CA | ACHY | AR] | RICUL | . V | | ine | 14 | , | | | | | |
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| of deal 1 Yes 2 No No No No No No No | | | | | n in Part I. | erlying cause gr | ulting in the ur | eath but not res | entributing to de | icant conditions of | Part II. Other signifi | hys | by the | 9 | | | |
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| 25. Was case referred to medical exeminer? Comparison | es 200 No | 2,1 No 1 □ Y | 1 □ Yes 2) | | | | | | | | | S | - N M | = 6 | | | |
| Continue | | | Check only one) | Death (| | | | | (In a share | red to medical | 25. Was case reterre exeminer? | 0 | N | 1 | | | |
| 2 Accident and Section (Street and Number or Rural Rolling) 2 Sec. Place of Injury - At home, tarm, street, factory, office 2 | | | | 1 | at ? | 28c. Inju Wo | P 1 | | | | | - | R | | | | |
| | oute Number, | 28t. Location (Street end Number or Rural Route Number, City or Town, State) | | | not be 28e. Place of Injury - At home, tarm, street, factory, offica | | | | | 6 Could not be | 3 Sulcide | ertifica | # 5 5 | DIVIS | | | |
| E + 1 | d. e cause(a) | (s) and manner as state and placa, and due to th | due to the cause(s) at the time, date and | laca, en | the basis of examination and/or investigation, in my opinion, death or | | | | | | | | | | | | |
| and manner stated. 29c. License number 29d. Date signed (Month, Dey. | /, Year) | Date signed (Month, De | 29d. Dat | | 29b. Signature and title of certifier 29c. License number | | | | | | | To the | 1 | | | | |
| Dean L. Variar D16036 September 9 | 7 1997 | ptembo, c | Son | | 036 | DI | | ann | L. U | Depa | | | 2 - 0 | | | | |
| 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print) Dean L. Vassar M.D. 110 Plumtree Lane, Bel Air, MD. 21015 | | , romes | | นก | | int) | n 23a) (Type, I | e ot death (Iter | ompleted caus | | | | 8 | , | | | |
| State Registrar SEP 10 1997 State SEP 10 1997 | | | 21015 | vIV. | AUL, M | | | | | | | | | | | | |

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3:17 George Gentry prember 4a. Fecility Name (If not Institution, give street end number) 4b, City, Town, or Location of Death 4c. County of Deeth Hospital andal/stown If Under 24 Hrs. 8. Date of Balto Northwest if Under 1 Year 8. Date of Birth (Month, Day, Year) 12-30-1932 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) 1∭M 2□F Days 212-26-4464 64 Yrs. Usual Residence of Decedant 10h County 10a State 10c. City, Town or Location 10d. Insida City Limits 1 Yes 2 No atons ville 10e. Street and Number 10g. Citizen of Whet Country? Agno 1211 21207 12. Was Decedent Ever in U,S. Armed Forces?

1 △ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Maritat Status 1 Never Married 2 Married Black 1 Yes 2 No Specify: 3 ☑ Widowed 4 ☐ Divorced 15. Decadent's Education (Specify only highest grede completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Baltimore City Collaga (1-4or 5+) 12 th grade Master's Degree Claims Specialist 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Malden Surneme) Gentry LUOVU tis Gentry 19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, State, Zip Code) 2.11.33 19a Informant's Name/Relationship (Type, Print) Halph Gentry 200. Method of Disposition Randalls tow red ca of Disposition (Name of netery, crametory or other pleca) 20b. Placa Date 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensea Name end Address of Facility 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Md Approximete Interval Batwean Onset and Death Immediata Cause (Final disease or condition resulting in death) Due to (or as a con: Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

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Records, P.O. Box 68760

Division of Vital

Physician

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7 is marked other than "netural", or items 23s or 28a-f show traumstic event, the Modical Examiner must be notified at

filed within 72 hours efter Hygiene.

permit. Pages 1 and 2 should be filed within Depertment of Health and Mentel Hygiene. Important: If item 27 is marked other than eny injury or other traumetic avant

Baltimore, Maryland 21215-0020

the Maryland

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in daath) Last Physician/Medicai

1 Yes 2 No 3 Probably 4 Unknown by 24b. Ware autopsy findings evelleble prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 2 1 No 1 ☐ Yea 2 ☐ No 25. Was casa raferred to medical examiner? 26. Placa of Daath (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Medical Certification: 5 Pending invastigation Natural 1 Yes 2 No 2 ☐ Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicida Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

of effections of the state of t in by To the Hospital or within 24 hours eff To the Funeral Di completely filled in

29b. Signature and title of certified

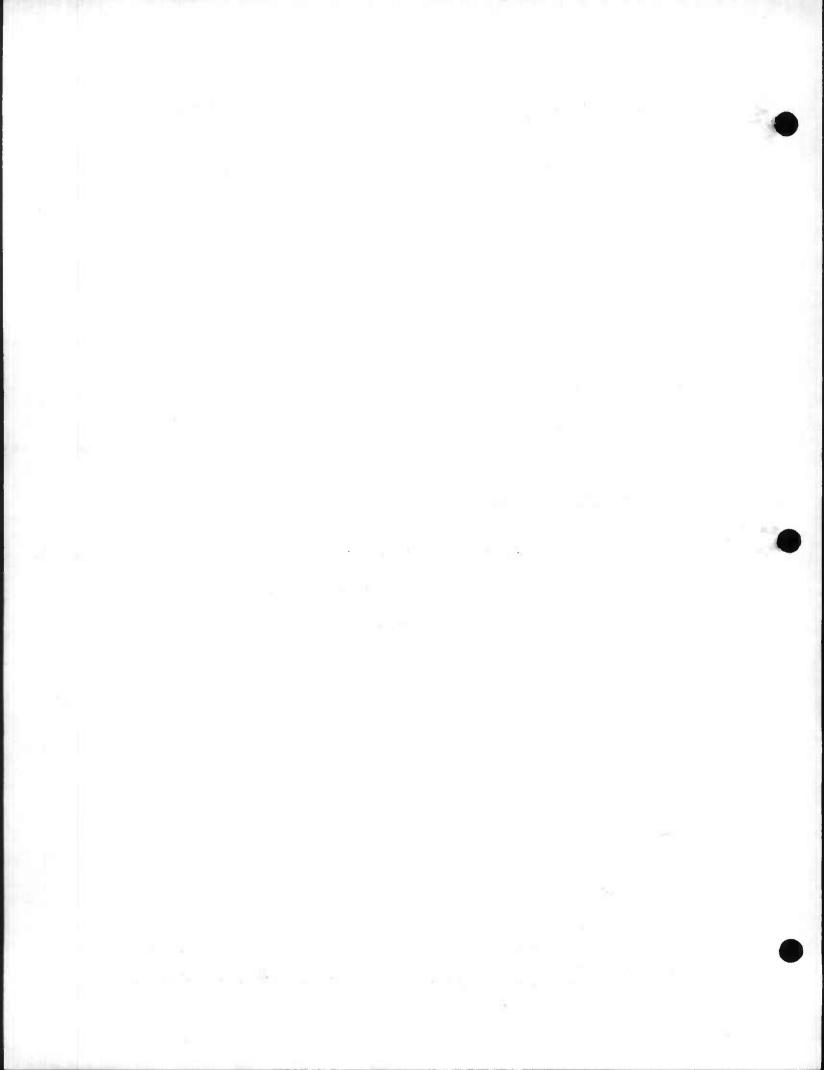
29d. Date signed (Month, Dey, Year)

30. Name and address of person who complated causa of death (Itam 23a) (Type, Print)

KOBERT M YACYNYLH MO 31. Data filed (Month, Day, Yaar)

32. Registrar's Signature

State Registrar

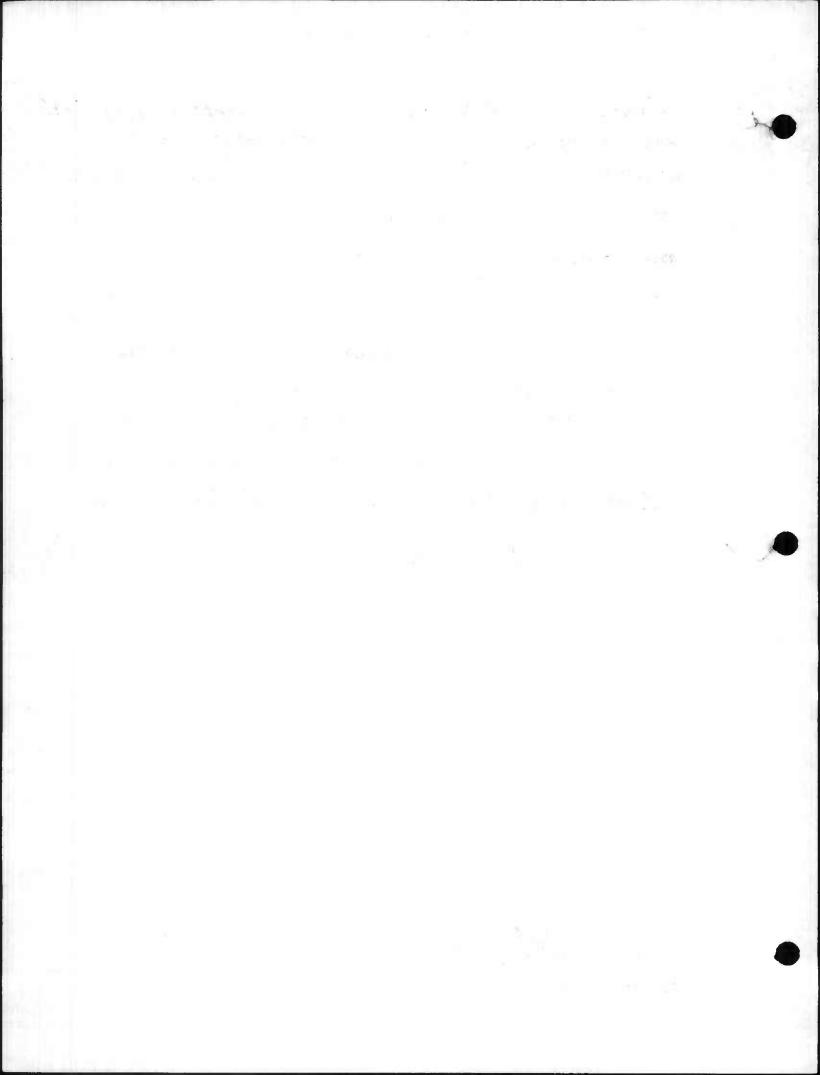


State of Maryland / Department of Health and Mental Hygiene 97

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| | Physic /Medi | | Jame | - 5 | 6 | rigs | by | | | Sep | + Day | Yaar /997 | 0245 | |
| 1 | Exami | | 4a. Facility Neme (II | | e street and numb | ber) | 7 | | 4b. City, Town | n, or Location of I | Death 4c. Coun | ty of Death | | |
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| | th with 23a or | □ | 102/ 17+ | h ST. NW | | | | 20009 |) | | | | · | |
| | Seath The 2 | era | 11. Marital Status | .II 31. NW | 12. Was Deced | ant Ever in U,S. | 13. V | | | n? (Specify Yas o | USA or No- 14. Re | ce - Americ | an Indian. | |
| 21215-0020 | 72 hours after death with the Maryland insture!; or Items 23s or 28s-f show digs! Examiner must be notified at | Completed by Funeral Director | A | ed 2 Married | Armed Force 1 ☐ Yas 2 If Yas, Give Yaar or Date | es.? □X0 | | Yes, specify (☐ Yas 2 📆 | of Hispanic Origi Cuben, Maxican, No <i>Specify:</i> | Puèrto Rican, atc | Speci | ack, Whita, | | |
| 0-10 | "natural", | pet | | 15. Decedant's Ed | lucation | | 16a. Deced | ant's Usual Oc | cupation | | 16b. Kind of I | Businass/Inc | dustry | |
| 218 | e 1 10 | ple | (Space Elamantary/Secon | ify only highast gra | da com <i>plated)</i> College (1-4 | lor 5 i | (Give | kind of work do OO NOT use ra | ona during most o tired) | of working | PRIVA | | , | |
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| ary. | should nd Men marke | - | 19a. Informant's Na | | | | 19b. Mailin | a Addrass (St | | | umber, City or Town | n. Stata. Zip | Coda) | |
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| Bal | permit. Pag Depertment Important: I any Injury o | | 21. Signature of Fur | _ | | | 22 | . Nama and Ad | Idrass of Facility | POPE FUN | ERAL HOME | S | | |
| _ | 20240 | | Kirty | ta. Su | rege MI | 1085 | 5 | 538 MAF | RLBORO P | IKE FORE | STVILLE N | | 46 | |
| | | | 23a. Part 1. Enter the shock, or haar | a disaasa, or com | olications thet cau | sed tha daath. | Do not ente | or the mode of | dylng, such as ca | ardiac or raspirate | ory arrast, | | Approximata Interval Batwaan | |
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| 0 | g Ph terth | | 27. Mannar of Death | | 28a. Data of | injury 28 Day Year) | Bb. Tima of Injury | 28c. I | njury at Work? | 28d. Dasc | ribe how injury occu | irred | | |
| Division | Attanding ir death. Actor: After by the fune | Certification: | 2 Accident | 5 Panding Invastigation | | | ,, | | 1 Yas 2 No | | | | | |
| Vis S | After de acto | 1 | 3 ☐ Suicida 4 ☐ Homicida | 6 Could not be datarmined | 25a. Place of | Injury - At home , atc. (Specify) | a, farm, stra | at, factory, off | ica | 28f. Locat | ion (Street and Nun r Town, Stata) | ber or Rura | I Routa Number, | |
| Ö | al or A | le l | 4 🗆 Homolog | | building | , atc. (Specify) | | | | Ony o | Town, State | | | |
| | splt hour ners y fille | | 29a. Cartifiar | Certifying Ph | yelctan: To the be | est of my knowle | dga, daath | occurred at th | a tima, data and | place, and dua to | tha causa(s) and n | nannar as si | tated. | |
| | To the Hospital or Attanding Ph. within 24 hours after death. To the Funeral Director: After thi completely filled in by tha funeral | edical | (Check only one) | 2 Medical Exam | iner: On the basi and manna | is of axamination r stated. | n and/or Inv | astigation, in n | ny opinion, daath | occurred at tha t | ima, data and place | , and dua to | tha causa(s) | |
| | To the To the Comp | Z | 29b. Signature and t | title of certifier | 1 | | | 29c. Lic | ansa number | | 29d. Date sign | ed (Month, | Day, Year) | |
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| | V | | 30. Name and addres | | omplated causa NER) M | 3720 | FAR | RAGUT | AVE H | KENSIN | GTON 1 | 10 2 | 0895 | |
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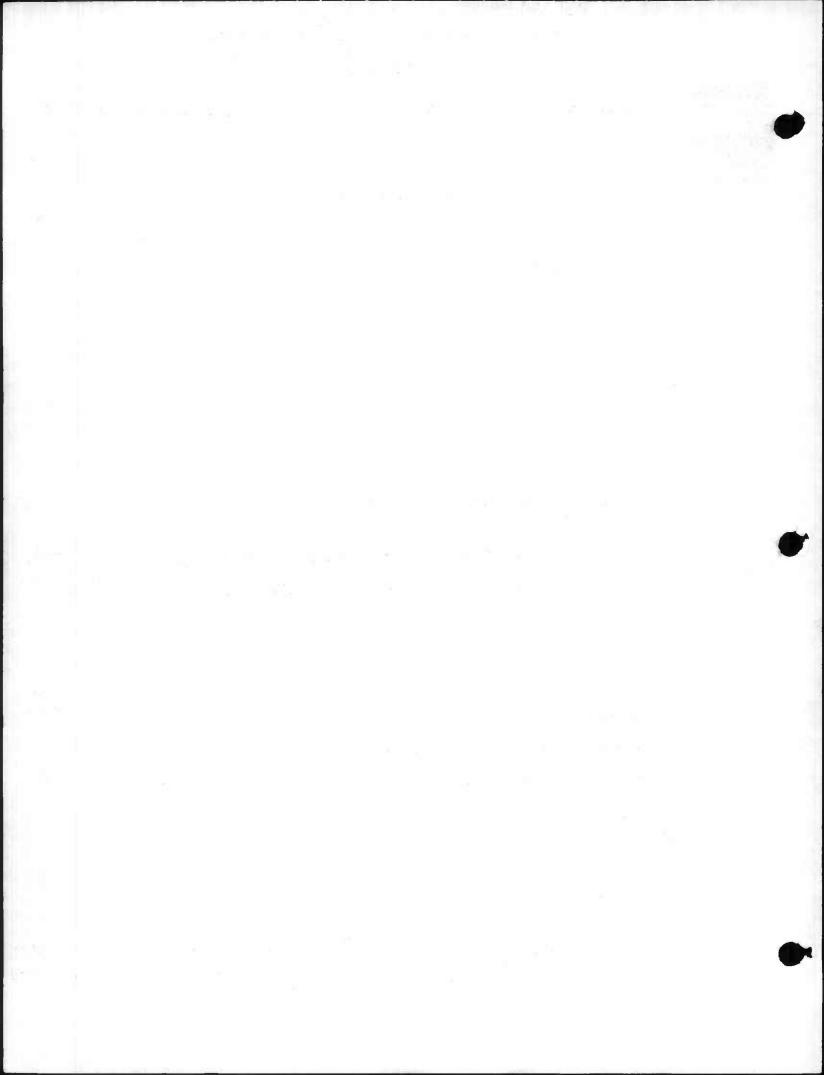


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Deeth **Physician** HORNE Month ANLEL /Medical 4a. Fecility Name (If not institution, give street and number 4c. County of Deel 4b. City, Town, or Location of Deeth Examiner HOS Kandallstown Balto If Under 1 Yaar If Under 24 Hrs. 8. Deta of Birth
Hours Min. (Month, Dey. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthdey) 9. Birthpleca (Stata or Foreign **Funeral** 15 M 2□ F 302-36-5362 68 Yrs Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits Director Ba 140 1 Yes 2 No Woodlawn 28a-f 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ò 12 03 M2. Was Decedent Ever in U,S. Armed Forces? 1 Myes 2 □ No Hyes, Gwa Yaar or Detes: 234 SA Funeral 'natural', or items 13. Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any Injury or other traumatic event, as Manical Examination. 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Completed by Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department Elamantary/Secondary (0-12) Collega (1-4or 5+) 12th grade 11/2 yrs chons Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Samuel Home Garnetta 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2/244 7203 -Wife Woodlawn, Mg Hor 20b. Plece of Disposition (Name of cematery, cremetory or other piece) mielier 20e. Method of Disposition

1 Seriel 2 Cremetion 3 Removel from Steta 20c. Location - City or Town, State Data 9-12-97 Ou 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee F. H.W 23e. Pert1. Enter the disease, or complications that caused the death. Do not entar tha mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one cause on each line. Avenue Md 21215 **Physician** /Medical Immediete Cause (Finel ELECTRICAL diseese or condition resulting in death) **Examiner** Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in daath) Lest bunial-tran Due to (or es e consequence of) P.O. Box 68760. Physician/Medical Dua to (or es a consequence of) Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uea contribute to the cause of death? 3 Probably 4 Onknown 1 Yes 2 No Records. À Completed OSSTRUCTIVE pulmoway Disitis 24a. Wes en eutopsy performed? 24b. Were autopsy findings aveileble prior to completion of cause of death? The law Conowany Antony DistASE 1 Yas 2 AN 1 Yes 2 No Be 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Propatient 2 ER/Outpetient 3 DOA 1 Yes 2 Certification: To 27. Manper of Death 28e. Dete of tnjury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending invastigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28a. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 4 T Homicide To the Hospital Within 24 hours a To the Funeral D Medical 29a. Certifier 1 Pertifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner as stated.
2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end plece, and due to the ceuse(s) end menner stated. 29b. Signeture end title of ceptifiar 29c. License number 29d. Dete signed (Month, Dey, Year) 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

62. Registrads Signeture

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27405 Certificate of Death Items: 27, 28a-f per MEO G-757 3/30/98 dh 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** Month HUNT 10:15 Am Q /Medicai 4a. Facility Name (If not institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Death Baytimore Examiner Medical If Undar 24 Hrs. 8. If Undar 1 Year 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) **Funeral** Days -68-1989 1 M 2□ F Yrs. Director Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location Inside City Limits traumatic event, the Medical Examiner must be notified at Baltimore 1 Yas 2 No Maryland Director 10e. Streat and Number 10f. Zip Coda 10g. Citizan of What Country? 8 USA Brock-238 Funeral 12. Was Decedant Evar in U,S Armed Forces? 14. Race - Amaricen Indian, Black, Whita, etc. filed within 72 hours after 1 Yas 2 No If Yes, Giva Year or Dates: 1 Navar Married 2 Marriad Black Baltimore, Maryland 21215-0020 ŏ 1 Yas 2 No Specify: by 3 Widowad 4 Divorced 'natural', Completed 15. Dacedant's Education (Spacify only highest grade completed) 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry al Hygiene. Elamentary/Sacondary (0-12) Collega (1-4or 5+) Safeway Deliver 17. Fathar's Nama (First, Middla, Last) Pages 1 and 2 should be file ment of Health and Mental Hy ant: If them 27 is marked oth jury or other traumatic event Be - Hung Moseph 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Ballimore, MD. 20c. Location - City or Town, Stata MD. 21244 Barbara 17m Broo 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 1 Burlal 2 □ Cramation 3 □ Ramoval from Stata Department of Important: If any injury or once. Con. 9/15 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funaral Sarvica Licensee Maryland 21229 23a. Part1. Entar the disease, or complications that caused the death. Do not antar the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immadiata Causa (Final disaasa or condition rasulting in daath) Encephalopathy Examiner Examiner The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Records, P.O. Box 68760, Physician/Medical Rena Failure Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contribute to the cause of death? 3 Probably Unknown cerebral 1 Yes 2 No þ 24b. Wara autopsy findings available prior to complation of ceuse of death? Completed cocaine ABuse 24a. Was an autopsy performed? icate has DEPTRSSION 1 Yas a No 1 Yas 25. Was cesa rafarrad to medicel axaminar? Be 26. Placa of Death (Check only ona) Hospital: 1 ☐ Yas 2 No Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) Certification: To Inpatient 2 ER/Outpatiant 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mannae of Death 28b. Tima of Injury 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding Invastigation Hateral 1 ☐ Yas 2)(X)No 2 Accident Sept. 2, 1997 unknown after de Director 6XXCould not be datarmined 3 Sulcida 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 4 Homicida To the Hospital or within 24 hours and To the Funeral Di completely filled in unknown unknown Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceusa(s) and manner stated. Medical 29a. Certifian

Terance State

29b. Signatura and titla of certifian

(Check only one)

32. Ragistrar's Signatura

MID.

30. Nama and addrass of person who complated causa of death (Itam 23a) (Typa, Print)

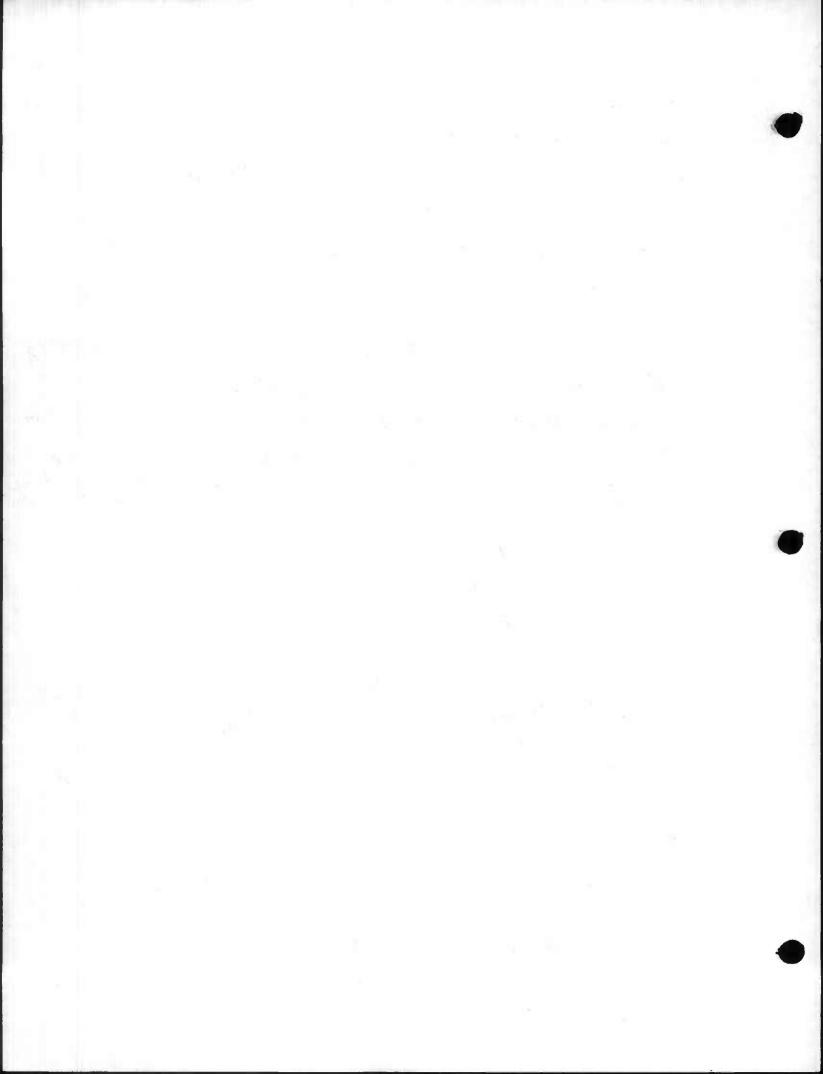
29c. Licansa number

Liberty medical Center, Baltimore Md 21215

29d. Date signed (Month, Day, Year)

Registrar

Derance &.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item 20b Per FH Film G751 8-10-97 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 100 kinor saltimore If Under 24 Hrs. 5. Sociel Security Number If Under 1 Year 8. Dete of Birth (Month, Dey, 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Deys Hours Min. 1 M 28 F 217-24-431 Yrs Director North Carolin Usual Residence of Decedent the Maryland 10b. County 10e Stete 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director 12 Yes 2 No Baltimore 10e. Streef end Number 10f. Zip Code 10n Citizen of What Country? 6 2333 23a Funeral Rems 2 12. Wes Decedent Ever In U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus Rece - American Indian, Bleck, Whife, etc. 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 PNo ŏ Baltimore, Maryland 21215-0020 1□ Yes 2€ No py Specify: Negro 3 ₩idowed 4 Divorced 'natural', Completed 15. Decedent's Education 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementery/Secondery (0-12) College (1-4or 5+) tousewife 5 permit. Pages 1 and 2 should be file Deperment of Health end Mental Hy Important: If them 27 is marked othe any Injury or other traumatic avena-17. Fether's Neme (First, Middle, Last) 18. Mofher's Neme (First, Middle, Melden Sumeme) Be Va Sudie Jones 19a. Informent's Neme/Reletionship (Type, Print & Ca. 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Grandson) 2607 Quantico ave, Baltame 21215 erome 20a. Method of Disposition 20b. Place of Disposition (Name of Western Star Dete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetlon 5 ☐ Other (Specify) 21. Signeture of Funerel Service Lice 2 Winorth unar Home Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart fellure. List only one cause on each line. Approximate tntervel Between Onsef end Deeth **Physician** /Medical tmmediate Ceuse (Final 0 disease or condition resulting in deeth) Examiner es/a consequence of): The law requires thet the death certificate be executed and Sequentielly list conditions, if eny, leeding to immediate cause. Enfer Underlying Cause (Diseese or injury that initieled events resulting in deeth) Lest Due to (or es e con ettending physician a for use es the burial-Records, P.O. Box 68760 Physician/Medicai Due to (or es e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? cate has been signed by pege 2 should be detect 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings eveitable prior fo completion of ceuse of deeth? Completed 24a. Was en eutopsy performed? certificate Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I Be 25. Wes cese referred to medical exeminer? 26. Plece of Deeth (Check only one) S No Other: To 1 Yes 1 ☐ tnpatienf 2 ☐ ER/Outpatienf 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) Menner of Deeth 28e. Dafe of Injury (Month, Dev Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Medical Certification: Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide Location (Street and Number or Rural Route Number, City or Town, State) Plece of Injury - At home, farm, sfreef, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the cause(s) end menner es steted. Medicaf Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, dete and place, end due to the ceuse(s) end menner steted. 29b. Signature and title of cedifier 29c. License number of deeth (Item 23a) (Type, Print) 30. Name and address of p irson who completed cause Uso era marie

44

32. Registrer's Signature

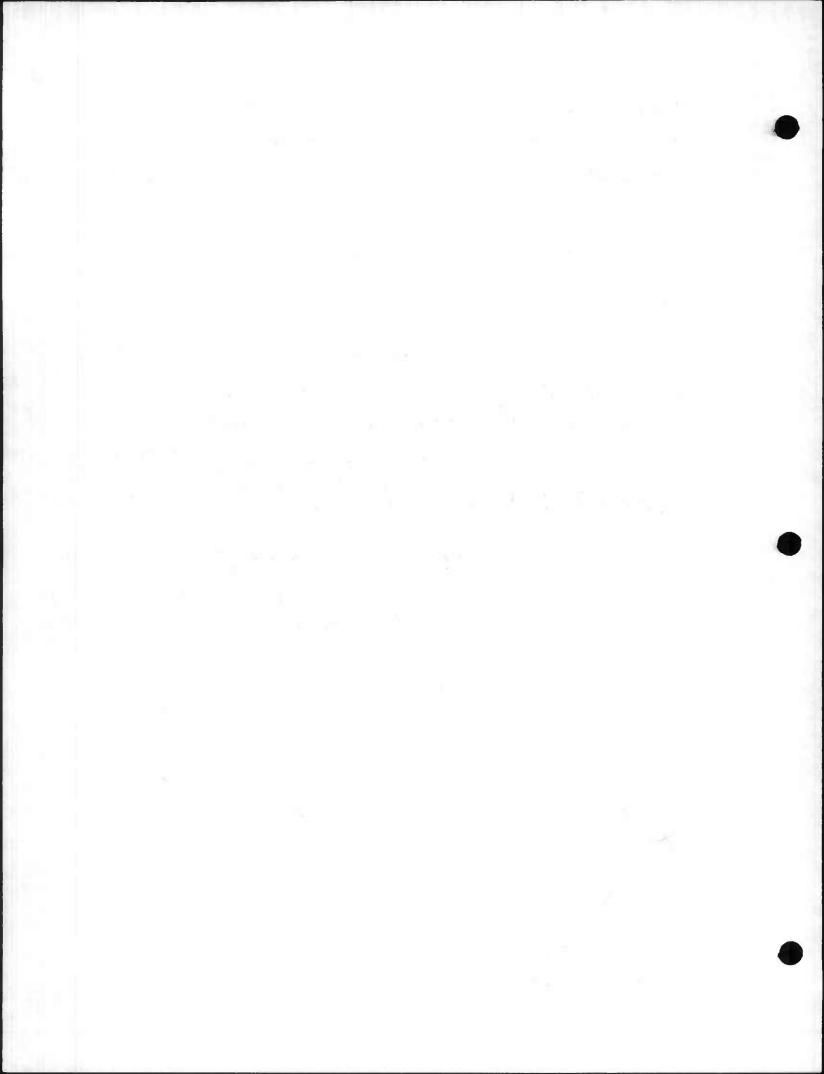
elia Davidson

State

Registrar

31. Dete filed (Month, Dey, Year)

SEP 1 0 1997



97-5047-510 CMK CHARLES HAWKINS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

HAWKINS

2. Dete of Deeth

Month

4b. City, Town, or Location of Deeth

111 Penn Street, Baltimore, Maryland 21201

Day

SEPTEMBER 05, 1997

Physician /Medical **Examiner**

Baltimore, Maryland 21215-0020

1. Decedent's Name (First, Middle, Last)

HARLES

4a. Facility Name (If not institution, give street end number)

Division of Vital Records, P.O. signed by the Hospital or Attending Physician:
124 hours effer death.
 Funeral Director: Affer this certifica funeral director, To the To the To the F

2900 GARRISON BOULEVARD-SIDE PORCH BALTIMORE CITY NIA 6. Sex 1 M M 2 ☐ F If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) AUG. 7, 1928 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) Months 69 Yrs. 215-22-6010-A Usual Residence of Decedent Director MARYLAND the Meryland 10a State 10b. County 10d. Inside City Limits notified at 1 Yes 2 No Director MARYLAND 10e. Street end Number log. Citizen of What Country? must be n AVENUE 2703 USA. Funeral Was Decedent Ever in U,S. Armed Forces?

1 XYes 2 No. 3-4-46
If Yes, Give
Year or Dates: 11-3-47 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 7 is marked other than "natural", or item traumatic event, the Medical Examiner Pages 1 and 2 should be filled within 72 hours after nent of Health and Mentai Hygiene. int: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry i Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) PORK PLAZA 12 TH GRADE WAITER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) CHARLES 0 HAWKINS BRISCOE LENA 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) AVE' HAWKINS (BROTHER) 823 KEVIN ROAD, BALTIHORE MD. 21229

20b. Place of Disposition (Neme of Dis 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State injury or METRO CEMATORY 9-9-97 BALTIMORE, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 3 Name and Address of Facility TOSEPH H. BROWN JR. FUNERAL HOME, P. A. 2140 N. FULTON AVE. BATTHORE, MD. 21217

Approximate heart failure. List only one cause on each line. Physiclan Immediate Ceuse (Finat CIPPLHOSIC OF LIVER diseese or condition resulting in deeth) Due to (or as e consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last burial-trar Due to (or as e consequence of): pue Physician/Medical Due to (or as a consequence of) Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24a. Was en eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed PARTIAL TOYES 2 No 25. Was case referred to medical examiner?
12€ Yes 2 □ No 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 XIOther (Specify)AT SCENE 27. Menger of Death 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? 5 Pending Investigation 1 Naturat 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signaure and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. SEPTEMBER 05, 1997 eddress of person who completed cause of death (Item 23a) (Type, Print) MALYDMM 31. Date filed (Month, Dey, Year)

32. Registrars Signature

State Registrar

SEP 1 0 1997

Ann Ann Stage son Stage son

Allowers and the second

NEW AND ADDRESS OF THE STATE OF THE STATE OF THE STATE OF THE

State of Maryland / Department of Health and Mental Hygiene

| | | | | or ivialylali | | | | Death | ivientai m | Reg. No. | 1 2 | 7408 |
|------------|---|--------------------------|--|---|--|---------------------------|--------------------------|--|--|--------------------------------------|------------------------------|--|
| | Physic /Medi | | 1. Decedent's Name (First, Middla, Last) Charlts Hay | rison | | | | | 2. Date of D Month | Day | Yaar 1997 | 3. Time of Death 4:3D AM |
| | Exami | | 4a. Facility Name (If not institution, give street and Sinal Hospital | d number) | · - | | | 4b. City, Town, or BAITI | Location of Dea | | | |
| | Funeral Director | | 5. Social Security Number 220 3 to 98 to 1 M 2 | 7. Age (In yrs. I | last birthday) Yrs. | If Under Months | 1 Year Days | If Under 24 Hrs Hours Min | | A . A | | ace (State or Foreign Iny) Maryland |
| | h the Maryland r 28a-f show | ctor | 10a. State 10b. County Maryland Baltimore | 10c. City | y, Town or Loc | cation | 6 | | | | 10 | 0d. Insida City Limits 1 ☐ Yes 2 Ø No |
| | 23a or 24 | ai Dire | 10e. Street and Number 2104 Pitney Rd. | | | 10f. Zip | Code | 21234 | | 10g. Citizen of | What Count | ry? |
| 020 | or Items | by Funeral Director | 1 Navar Married 2 Married 1 1 Yes | Decedant Evar In U, d Forces? es 22 No , Give or Dates: | | | | lispanic Origin? (San, Mexican, Puer Specify: | Specify Yes or N to Rican, atc.) | o- 14. Rac Bia Specify | ca - America ck, White, e | etc. |
| 21215-0020 | | Completed | 15. Decedent's Education (Specify only highast grada comple Elementary/Secondary (0-12) 12 Colla | ted) ga (1-4or 5+) | | kind of worl O NOT use | Occup dona retired | during most of wa d) | nrking | 16b. Kind of B | usiness/Ind | |
| Maryland | 2 should be filed and Mental Hygie is marked other aumatic event, it | To Be | 17. Father's Name (First, Middle, Last) John W. Harriso | | | | | | Cecelia | Abert | ,5 | |
| | s 1 and 2 sh f Health and tem 27 is n other traun | | 19e. Informant's Name/Relationship (Type, Print) Janet Harrison 20a. Mathod of Disposition | | 19b. Meiling 210 lace of Dispose matary, cram | 4 Pit | ney | | Arkville | MAYYAY 20c. Location | nd i | 21234 |
| Baltimore, | permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiane. Importent: if Item 27 is marked other than any injury or other traumatic event, to a Monta. | k 10 | 1 Burial 2 Cremation 3 Removal f 4 Donetion 5 Other (Specify) 21. Signature of Funeral Service Licensee | Dulaney Valley Memorial Gardens 199- | | | | | | Timonivi of of Mem | ones | bralgral |
| | Physician /Medicai Examiner | | 23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one ceuse | nat caused the death on each line. | 1 | | of dyir | | | | | Approximate Intervei Between Onset and Death |
| | | | disease or condition resulting in death) | | | | | | | | | |
| 68760, | | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaasa or Injury that initieled events | Due to (or as a consequenca of): | | | | | | | | |
| Box 68 | E C0 05 | ian/Medicai | resulting in death) Last | | | | | | | | | |
| s, P.O. | requires that tha death cert een signed by the attandin hould be detached for use : | y Physic | Part II. Other significant conditions contributing COrchay aftery d | | | | | | | Yes 2/2 No | ntribute to | the cause of death? |
| Records, | | Completed by Physician/N | | | | | | | | s an autopsy ormed? | ava con | re autopsy findings iliable prior to apletion of cause leath? |
| (ital F | volodn: The aw his certificate has b il director, paga 2 s | Be | 25. Was casa referred to medical examinar? | | | | | | 1 🗹 ath (Check only | Yes 2□No | 1 🗆 | Yes 2/2 No |
| n of | <u> </u> | on: To | 27. Manner of Death 28e. D | Inpatient 2□ late of Injury Month, Day Year) | ER/Outpatient 28b. Time of injury | | oth ic. Injur Wor | 4 LI Nursing I | _ | idenca 6 Oth | |) |
| Division | frer deat | Certification: | 2 Accident Investigation 3 Suicide 6 Could not be determined 28e. F | laca of Injury - At ho uilding, etc. (Specify | me, farm, stre | М | 1 🗆 | Yes 2 □ No | 28f. Location City or To | (Streat and Numb own, State) | per or Rural | Routa Numbar, |
| | ne Hospital or Attend n 24 hours after death ne Funeral Director: plataly filled in by tha | edical Ce | 29a. Certifier (Check only one) 12 Certifying Physician: To the deciral Examiner: On the end of th | the best of <i>m</i> y know ne basis of exa <i>m</i> lneti nanner stated. | wledge, death ion and/or inve | occurred a estigation, | t the tin | ne, date and plac pinlon, death occ | a, end due to the urred et the time | cause(s) end ma , dete and pieca, | anner as sta and due to | ated. the cause(s) |

State Registrar

29b. Signature and titia of certifier

Fellie G. Cohen, MO

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

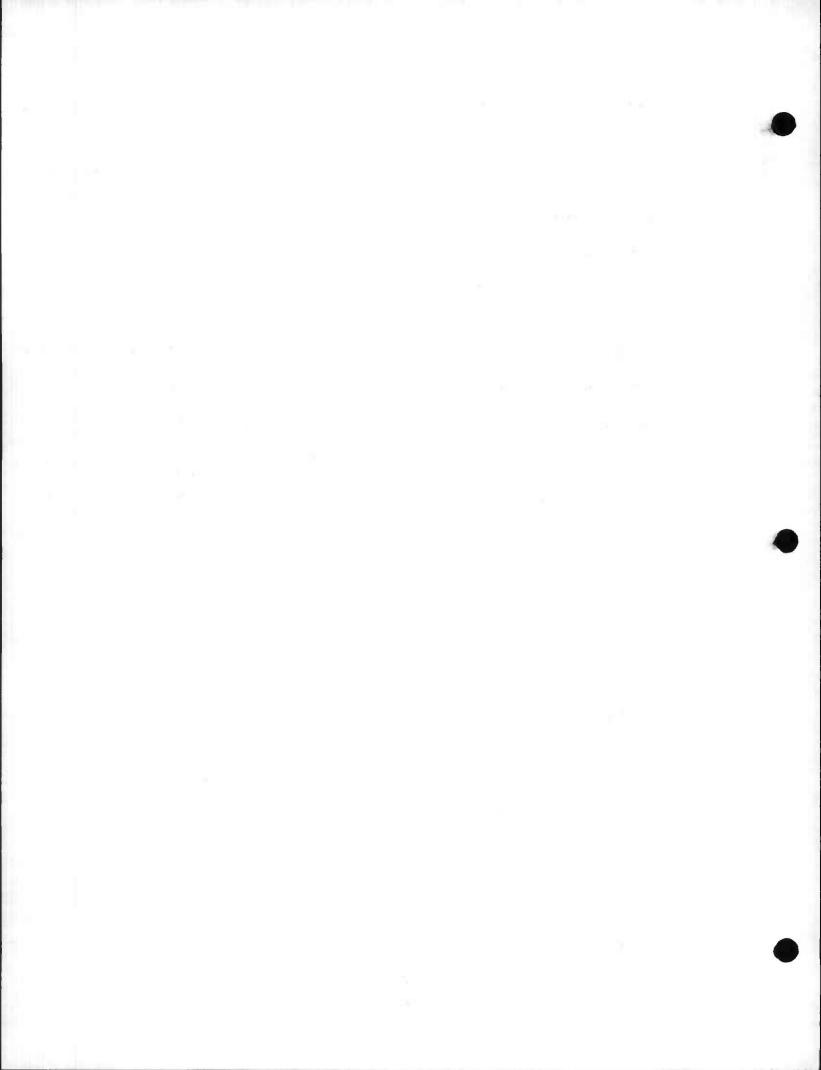
2401 H. Belvedere Ave. Baltimore MD Cohen M.D.

29c. Licansa number

29d. Data signed (Month, Day, Year)

21215

A52402321-EC9008 September, 9, 1997



State of Maryland / Department of Health and Mental Hygiene

| | _ | | | | | | Cei | titicat | e ot | Death | 7 | | eg. No. | | | 409 |
|---|--|--|----------|---|--------------|------------------------|------------------|--------------------------------|---------|------------------------|---------------------------------------|---|---------------------------------|------------------------------|---|------------------------------|
| Physician | | Decedent's Name (First, Mid | | | | | | | | | | 2. Dete of Deel Month | th Dey_ | Yeer | | ne of Deeth |
| /Medical | - | MARGARET MAR | Y H | AYNIE | | | | | | | | SCOTTEMBE | | 1997 | 12 | :30 PM |
| Examiner | | 4e. Fecility Neme (If not instituti | on, give | street and nu | mber) | | | | | 4b. City, To | own, or L | ocation of Death | 4c. Coun | ty of Deeth | 1 | |
| | | ST. AGNES HE | AL | THEAR | E | | | | | BALT | MOR | QM, 3. | | N/ | A | |
| Funeral Director | | 5. Social Security Number 213-38-9211 | 6. Se | ex □M 2□KF | 7. Age 84 | (In yrs. lest b | irthday) Yrs. | If Under Months | | | Min. | 8. Date of Birth (Month, Dey, SEPT 1, | Year) 1913 | 9. Birth Con MAR | plece (Si intry) LYLAN | ete or Foreig D |
| D | - 1- | Usual Residence of Decedent | - | | | | | | | | | | | 1 | | |
| per incomment of mours after dearn with the maryland ital Hygiene. Ital Hygiene. of other than "natural", or items 23a or 28a-f show event, its Medical Examiner must be notified at Be Completed by Funeral Director. | - 1 | MD 10b. Count | y TIM | ORE | | 10c. City, Tov | | cation STERS | row | N | | | | | | de City Limits Yes 201 No |
| or 28 | 5 | 10e. Street end Number | | | | | | 10f. Zip | Code | | | 1 | 0g. Citizen o | f Whet Cou | intry? | |
| 23a o | 2 | 409 FOXVIEW | COU | RT | | | | | 211: | 36 | | | U. | S.A. | | |
| r items 23s | 5 | 11. Meritel Status | | 12. Was Dec | edent Ev | ver in U,S. | 13. \ | Ves Deced | lent of | Hispenic Or | rlgin? (Sp | pecity Yes or No- | | | | in, |
| al', or items | | 1 Never Married 2 Ma 3 Widowed 4 Divorce | | Armed Fo 1 ☐ Yes If Yes, Gir Year or D | 2 1 No | 0 | | | | oan, Mexice Specify | | | | | Race - Americen Indien, Bleck, White, etc. | |
| "natural", | | 15. Decede | nt's Ed | ucetion | - | 166 | e. Deced | fent's Usua | I Occu | pation | | | 16b. Kind of | b. Kind of Business/Industry | | |
| led within 72 ho ygjene. ner than "naturi nt, the Medical Completed | 2 | (Specify only high | est grad | de completed) | 1.4005. | | (Give life. l | kind of wor | k done | during mo | st of worl | king | | | | |
| than the | 5 | Elementery/Secondary (0-12) 6TH GRADE | | College (| 1-40r 5+ | | OMEN | 1AKER | | | | | | HOME | MAKI | NG |
| and Mental Hygiene. S marked other than humatic event, the | 2 | 17. Fether's Neme (First, Middle | , Last) | | | | 49 | | | 18. Moth | er's Nam | e (First, Middle, I | Maiden Sume | me) | | |
| Menta arked atic ev | | WILLIAM FRAN | ΙK | | | | | | | | NORA | A KEARNE | Y | | | |
| and Men is marke aumatic | | 19e. Informent's Name/Reletion | ship /7 | vpe. Print) | | 19 | b. Mailir | a Address | (Stree | t end Numb | er or Ru | rel Route Number | City or Tow | n Stete 7 | in Code) | |
| trau trau | | | | | | | | | | | | 2113 | - | | | |
| Health and Mental Hygiene. tem 27 is merked other than "nature other traumetic event, the Medical To Be Completed | - | 20a. Method of Disposition | - | | | 20b. Place | of Dispo | sition (Nen | ne of | - | 1 | | 20c. Location | - City or 1 | own. Sta | te |
| 00-1 | | 1 🛣 Burial 2 ☐ Cremation 4 ☐ Donetion 5 ☐ Other (| | | State | | | metory or o | | ece) L PARI | C | 9/12/97 | SYKES | | | |
| pemit. Pag Department important: if any injury o | | 21. Signeture of Fun rel Service Licensee 22. Name and Address of Fecility HUBBARD FUNERALHOME INC. | | | | | | | | | | | | | | |
| 70 = 9 Q | 4107 WILKENS AVENUE-BALTIMORE, MD 2 | | | | | | | | | | 212 | 29 | | | | |
| hysician | 23a. Plat En er the disease, or complications that ceuse the queth. Do not enter the mode of dying, such as cardiac or respiretory arrest, or heart feilure. List only one ceuse on each line. | | | | | | | | | | 1 | | imete I Between end Deeth | | | |
| /Medical | 1 | Immediate Cause (Finel disease or condition | | RF | SP | IRAT | OR | YY | 216 | NE | 22 | | | 1 | IL | EEK |
| xaminer | 1 | resulting in death) | | ө. | | Due to (or es e | | | /13 | 100 | | | | 1 | | |
| ě | 5 | | | PA | | MON | | , | 0.0 | ATT | 100 | | | 4 | 3 W | EEKS |
| in and fightransk | | Sequentially list conditions | | b | | ue to (or es e | | , | 111 | -NI 10 | //~ | | | | 3 ** | |
| an and rial-tra | | Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thet initieted events | | 110 | | | | | | | | | | | | |
| physician as the buria edical E | 3 | Ceuse (Diseese or Injury thet initieted events | < | c. UK | | EPSI ue to (or es e | - | uence of | | | | | | - | | |
| fig p | 3 | resulting in deeth) Lest | | | D | de to (or es e | conseq | dence oi). | | | | | | | | |
| | | | | d | | | | | | | | | | | | |
| 하 하 하 | 3 | 5 . 0 . 6 | | | | | | | | | | 1 | | | | |
| y the sched | 2 | Pert il. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contrib | | | | | | | | / | | | | | | |
| gred by be detail | SACRAL DECUBITUS ULCER (STAGE IV) 10 Yea 20 No 36 | | | | | | | | 3 2 Pr | obably | 4 Unknow | | | | | |
| page 2 should b | | DEMENTIA | IEMENTIA | | | | | 24e. Wes en eutopsy performed? | 8 | vailable p | psy findings rior to n of cause | | | | | |
| page page | 8 HYPERTENSION 10 Yes 28 | | | | | | | s 2 No | 1 | ☐ Yes | 2 No | | | | | |
| £ 5 0 |) | 25. Wes case referred to medic | | | | | | | | 26. Plec | e of Dee | th (Check only on | e) | | | |
| sicia inect finect O B | | exeminer? 1 ☐ Yes 2 ☑ No | | Hospitel: | Inpatient | t 2□ FB/O | utnetien | t 3 DC | A O | her: | | ome 5 Reside | | ther (Snec | ifu) | |

NAME, HAYNIE, MARGARET M Division of Vital Records, P.O. Box 68760,

State Registrar

Certification: To

Medical

27. Menner of Deeth

1 Neturel

2 Accident

3 Suicide

29e. Certifier

4 - Homicide

5 Pending Investigation

6 Could not be determined

(Check only one) 29b. Signeture end title of

Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

28c. Injury et Work?

28e. Date of Injury (Month, Dey Year)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner steted. 29c. License number 29d. Dete signed (Month, Dey, Yeer)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

SEPTEMBER 8, 1997

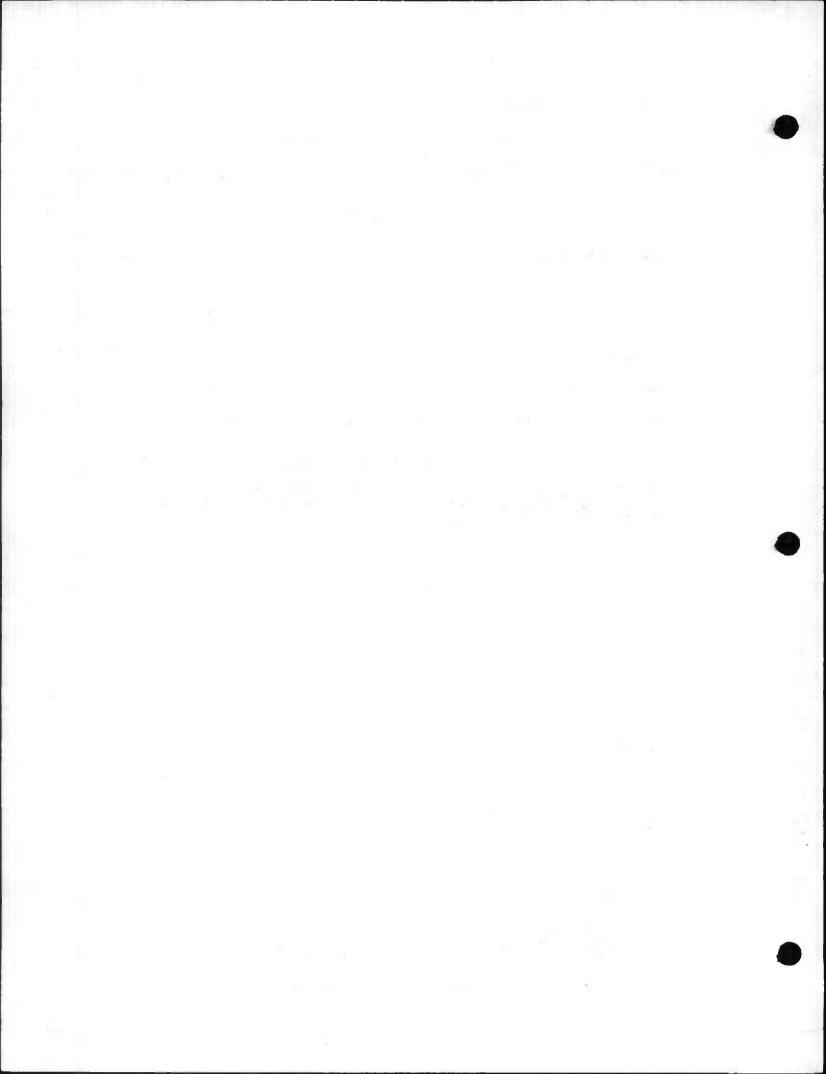
M.D. 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

ST. AGNES HEALTHCARE, 900 CATON AVENUE, BALTIMORE, MO, 21229

P11704

1 Yes 2 No

GHANI , M.D

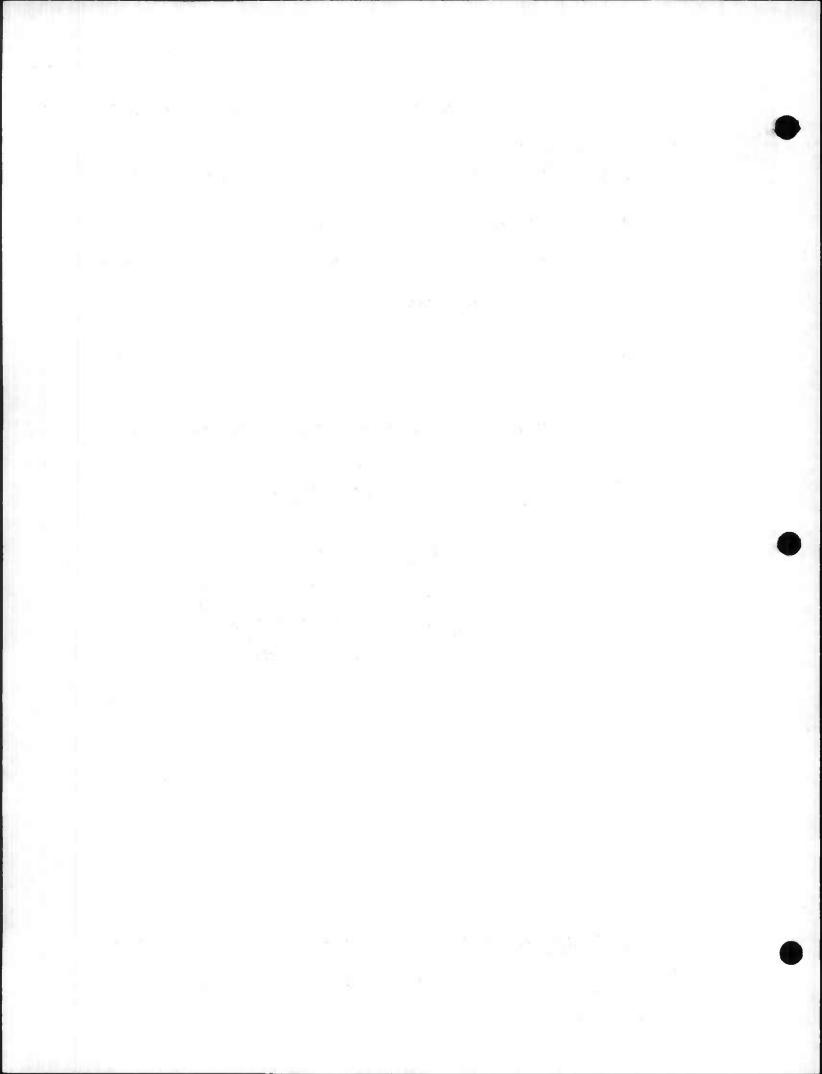


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

7 2

| | | _ | | | | Certi | iicale o | Dealli | | Reg. No. | | | |
|--|----------------|---|--|--|------------------------------|-----------------------------|--------------------------------|------------------------------|-------------------------------------|---|---------------|--|--|
| | sicia edica | _ | Decedent's Name (First, Middla, La William | | Arth | ur | J | ONES | 2. Date of D Month Septem | Dey | Yaar 1997 | 3. Tima of Deeth 8:10 PM | |
| | mine | er | 4a. Facility Name (If not institution, giv | the state of the s | | | | | or Location of Dea | th 4c. Cour | nty of Death | | |
| - | | | Franklin Square H 5. Sociel Security Number 6. S | | enter ge (In yrs. last bi | irthday) | if Under 1 Yes | Rosedal or If Under 24 I | | | imore | ana (Stata as Familia | |
| Fune Direc | | | 189-05-0170 | KDM 2□ F | 79 | | Months Dey | | lin. (Month, D | , 1918 | Penns | ece <i>(State or Foreigi</i> ry) ylvania | |
| and ** | | - 1- | Usuei Residence of Decedent 10a. Stete 10b. County | | 10c. City, Tov | vn or Local | tion | | | | 10 | Od. Inside City Limits | |
| be filed within 72 hours after death with the Maryland tall Hygiana. Outbut than "natural", or flems 23a or 28s-f show event. | | 2 | | altimore | | | Baltim | ore | | | | 1 ☐ Yes 2X No | |
| Vith the | | | 10e. Street end Number | | | | 10f. Zip Code | | | 10g. Citizen o | f Whet Count | ry? | |
| eath v | | era | 614 Delaware Aenu | e 12. Wes Decedant | Superio II C | 10.100 | | 221 | /O!/ // | 14.5 | U. S | | |
| fler d | | Funeral | 1 ☐ Never Merriad 2 ☒ Merried | Armed Forces? 1 X Yes 2 If Yes, Give | , | | | | (Specify Yas or Nuerto Rican, atc.) | B | ack, White, a | | |
| ours a | | 2 | 3 ☐ Widowed 4 ☐ Divorcad | If Yes, Give Yaar or Detas: | 1945-194 | 6 | Yes 200 N | o Specify: | | Spec | eity: Wh | nite | |
| d within 72 hours aff giana. rr than "natural", or | | Completed | 15. Decedent's Ed (Specify only highest gra | ducation da completed) | 166 | (Give kin | it's Usuei Occi | e during most of | working | orking 16b. Kind of Business/Indu | | | |
| filed within Hygiana. ther than | | mp | Eiemantary/Secondary (0-12) | Coilege (1-4or | | | NOT use retir | | | 36 | | | |
| Hygin | | | 12th Grade 17. Fether's Neme (First, Middle, Last) | | 4 | Alrer | aft Wo | | Name (First, Middle | | n Mari | etta | |
| nd 2 should be file lith and Mental Hy 17 is marked other traumatic event | | To Be | William Jones | | | | | Minni | e Sickle | r | | | |
| 2 should and Mer is marke | | | 19e. Informant's Name/Reletionship (| Type, Print) | 19 | b. Mailing | Address (Stre | et end Number of | Rural Route Num | ber, City or Tow | n, Stete, Zip | Code) | |
| | | - | | ife) | 6 | 14 De | laware | Avenue, | Baltimo | | | | |
| Pages 1 nent of H int: If Ite | | | 20e. Method of Disposition 1 🖾 Buriel 2 ☐ Cremetion 3 ☐ | Removel from State | anmote | of Dispositi ery, cremat | on (Name of lory or other p | lace) | Date | 20c. Location | - City or Tov | wn, Stete | |
| permit. Pages 1 ar Department of Hea Important: If Item 5 | | - | 4 Donetion 5 Other (Specify | | Oak L | | emeter | | 9/97 | Baltim | ore, M | laryland | |
| permit. Departr Import | ouce | | 21. Signature of Funaral Service Licen | 1500 | | | | ress of Fecility k Funera | 1 Home I | nc. | | | |
| - | | - | 23a, Part 1, Enter the disease or com- | nlications that cause | d the death. Do | 33 | 31 Bre | hms Lane | , Baltim | ore, Md | . 2121 | 3 Approximate | |
| Physicia | an | | 23a. Part1. Enter tha disaase, or comp shock, or heart feilure. List only | one cause on each li | ne. | 1 | ina moda or d | ying, socit es can | siac of raspiratory | anası, | | Intervel Between Onset and Death | |
| /Medic | al | | Immadiete Ceuse (Finel disease or condition | | 15 | TYM | Duce | A | | | i | 1 Days | |
| Examin | | | resulting in deeth) | θ. | Due to (ogas a | ogsequi | hos at | 1 | | | | l Day | |
| D 4 | | Kespirator in sufficiency | | | | | | | | | | | |
| and al-tran | | xan | Sequentially list conditions, if eny, leading to immediate | | Due to for as a | dinseque | noe of): | mile | 1 | / | | | |
| ifficate be asscuted g physician and as the burlat-transit | | cal | causa. Enter Underlying Cause (Diseese or injury that initiated events | C. | Due to (or as e | uu | nucci | inigo | ugue | in | | | |
| certificate be axecuted ding physician and see as the burial-transit | | Med | resulting in deeth) Lest | | ad | COLISAGUAL | dre I | whate | θ' | | i | | |
| | | | | d | | w | | 7 | | | 1 | | |
| the de | | Pnysicia | Pert II. Other eignificant conditions co | ontributing to death b | ut not resulting | n the unde | erlying cause of | oven in Part I. | 23b. Did | tobacco use o | contribute to | the cause of death | |
| that the ed by | č | | | | | | | | 1 | Yes 2 No | 3 Prob | ably 4 ☐ Unknow | |
| requires that the death been signed by the atter should be datached for o | | ad Da | | | | | | | 24a. Wa | s an eutopsy | 24b. Wee | re autopsy findings | |
| m requires the been signed as should be contact. | | Сощріете | | | | | | | pen | formed? | com | ilable prior to apietion of cause eeth? | |
| - | | E | | | | | | | 10 | Yas 2 No | 10 | Yes 2□ No | |
| old in | | | 25. Was case refarred to medical exeminer? | | | | | 26. Place of I | Deeth (Check only | one) | | | |
| Physic Of rai dire | i i | 0 | 1 Yes 2 No | Hospital: 1 Inpatie | 1 | | 3LI DUA | | g Home 5 ☐ Res | | |) | |
| Mac | | | | | | | | 28d. Dascribe | how injury occ | urred | | | |
| or Attending after death. Director: Afte | | 27. Menner of Death 1 Netural 2 Accident 3 Suicida 4 Homicide 28e. Data of Injury (Month, Day Year) 28e. Data of Injury M 28b. Tima of Injury M 28b. Tima of Injury M 1 Yes 2 1 Yes 2 1 Yes 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | 28f. Location | 28f. Location (Street and Number or Rural Route N | | | |
| affar Olive | 1 | Le L | 4 ☐ Homicide | building, et | c. (Specify) | , | , tuototy, omo | | | wn, Stete) | | | |
| To the Hospital or within 24 hours after To the Funeral Director completely filled in | | | 29a. Certifier 1 Certifying Phy | ysician: To the best | of my knowledge | e, deeth oo | courred et the | time, dete end pl | ece, end due to the | cause(s) end i | menner as ste | eted. | |
| the F | | Medical | one) 29b. Signetura and title of certifier | and menner ste | eted. | | | | COSTITUTE OF KIE CHILLS | | | | |
| To Too | | | Leb. Signatura arraytan of certifier | DAA M | 1 | | ZVG./LICA! | nsa number | | 29d. Deta sign | (Month, D | /ay, 1987) | |
| , X | | - | 30. Name end eddress of person who o | completed as as at | looth (Home OD-) | (Tues Del | 01 | 190 | | 4-4- | 7/ | | |
| 0, | | , | KAPAPL PORF | 2-MENA | uem 23a) U | 1)4 | "EATRE | RN BL | vo - | BALT | 0. 1 | MD. | |
| | State | 9 | 31. Dete filed (Month, Day, Year) | 39. Registr | ar's Signeture | 8 44 | | | | | 1 | | |
| | | | 000 4 0 4007 | The state of the | men de . (L) | mol a DO | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month September 8, 1997 4b. City, Town, or Location of Death | 4c. County of Dea 4a. Facility Name (If not Institution, giva street and number) 4c. County of Death BALTIHORE If Undar 24 Hrs. 8. Data of Birth Hours Min. FEB. 23, 1909 ENTER BERT MEDICAL NIA If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 215-09-2238 1 M 2 F Months Days Yrs. MARYLAND Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No NIA MARYLAND 10e. Street and Number 10g. Citizen of What Country? 2530 AMONT 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexicen, Puerto Rican, etc.) STREET USA. 12. Wes Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Year or Dates: 14. Race - Amarican Indian, Black, Whita, etc. 1 Nevar Married 2 Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) NURSE 12 HIGRADE ROSEWOOD HOSPITAL 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Surname) EPWARD FRANCES NAILER 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 3026 MOSHER STREET, MARY COBBS BALTIHORE, MD, 21216 20c. Location - City or Town, State MOTHER 20a. Method of Disposition 1 Burlal 2 Cramation 3 Removal from State Place of Disposition (Name of cemetery, crematory or other place) 9-13-97 ARBUTUS, MARYLAND ARBUTUS CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility TOSEPH H. & JR. FUNERAL HOME BROWN JOSEPH. FULTON AVE. Inter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heert failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disaasa or condition resulting in deeth) de Varculandre. Sequentially list conditions, if any, leading to immediate causa. Enter Undarlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Last typertence Due to (or as a consequence of) Part II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably Wunknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of ceusa of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was cese referred to medicel 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□ No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA

Physician /Medical **Examiner** burial-transit and physician s tha burial

Physician

/Medical

Examiner

Director

Funeral

A

Funeral

Director

7 is marked other than "naturel", or items 23a or 28a-f show treumstic event, the Medical Examiner must be notified at

permit. Pagas 1 and 2 should be filed within 72 hours aftar t Department of Haalth and Mantal Hygiena. Important: If Item 27 is marked other then "naturel", or ther any Injury or other treumatic event, ma Madical Examina

Saltimore, Maryland 21215-0020

the Maryland

with

daath

Physician/Medical by Completed Be To Certification:

27. Manner of Death

1 Natural

2 Accident 3 Suicide

4 | Homicide

29a. Certifier

Records, P.O. Box 68760. paga 2 should be detacl cartificata Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifical completely filled in by the funeral director,

edicai

State Registrar

29b. Signature and title of certifie

5 Pending Investigation

6 Could not be determined

My Dieai

28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify)

28b. Time of

29c. License number 20215

MP 21211

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

🔟 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s)

29d. Data signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed ceuse of deeth_(Item 23e) (Type, Print)

FALLS Read BALTIMORE 4411

31. Date filed (Month, Dey, Year) SEP 1 0 1997 32. Registrar's Signature Julie Tavidson-Randalles

28a. Date of Injury (Month, Day Year)

and mannar stated.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 27412 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Raymond Clarence Kennard sept. 8th 1997 8:50 DAM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Carroll County General Hospital Westminister Carroll If Under 1 Yeer Months Deys 6. Sex 5. Sociel Security Number 7. Age (In yrs. lest birthdey) If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) **Funeral** Birthpiece (State or Foreign Country) Min. Hours 88 Director 110-10-7889 Balto. Md. Oct.30,1908 Usuei Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits munt be notified at Md. City Director 1 Yes 2 No Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? b Items 23a 2913 Fleetwood Ave. 21214 Funeral USA 12. Wes Decedent Ever In U,S. Armed Forces?

1 ★ Yes 2 → No if Yes, Give Year or Dates: WW 2 14. Race - American Indien, Bieck, White, etc. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 natural, or White 1 ☐ Yes 2 No by 3 Widowed 4 □ Divorced Specify: Completed the Medical 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry filled within Hygiens. Elementary/Secondary (0-12) College (1-4or 5+) Officer 2 Yrs College Banking permit. Plages 1 and 2 should be file.
Department of Health and Montal Hyg.
Important: If Item 27 is marked any Injury or other to marked other 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Surneme) Be Raymond C. Kennard Sr. Zeora Boykin 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Tracy Kennard Imm 208 E. Chatsworth Ave. Reisterstown, Md. 21136 20b. Piece of Disposition (Name of cemetery, cremetory or other piece) 20e. Method of Disposition Dete 20c. Location - City or Town, State Buriai 2 Cremetion 3 Removei from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 9/11/97 Owings Mills, Md. Garrison Forest V.A.Cem. 21. Signature of Funerei Service License 22. Name end Address of Fecility 11824 Reisterstown Rd. ELINE FUNERAL HOME Reisterstown, Md. 21136 ine ant1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, flock, or heart failure. List only one cause on each line. **Physician** diete Ceuse (Finel dis ase or condition resulting in deeth) /Medical 2wks Examiner Due to (or es a consequence of): Examiner Hypotension requires that the death cartificete be axecuted the buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest pug Due to (or es e consequence of): P.O. Box 68760. Acute Renal Failure Physician/Medical Due to (or es e consequence of): for usa as Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown been signed be should be data Heart Failure. Connestive Records, p Be Completed 24e. Wes en eutopsy performed? 24b. Were autopsy findings evellebie prior to completion of cause of deeth? 200 No 1 Yes 1 ☐ Yes 2 ☐ No Vital 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospitei: 1 Inpatient 2 ER/Outpetient 3 DOA 2 No Other: 4□ Nursing Home 5□ Residence 6□Other (Specify) 0 1 Yes o 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Division After or Attending 5 Pending investigation 1. Neturai s aftar deeth. 1 Yes 2 No 2 Accident tha 6 Could not be determined 3 ☐ Suicide in by t 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, fectory, office 4 Homicide To the Hospital o within 24 hours af To the Funeral DI completally filled in Certifying Physician, to the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end menner es steted.

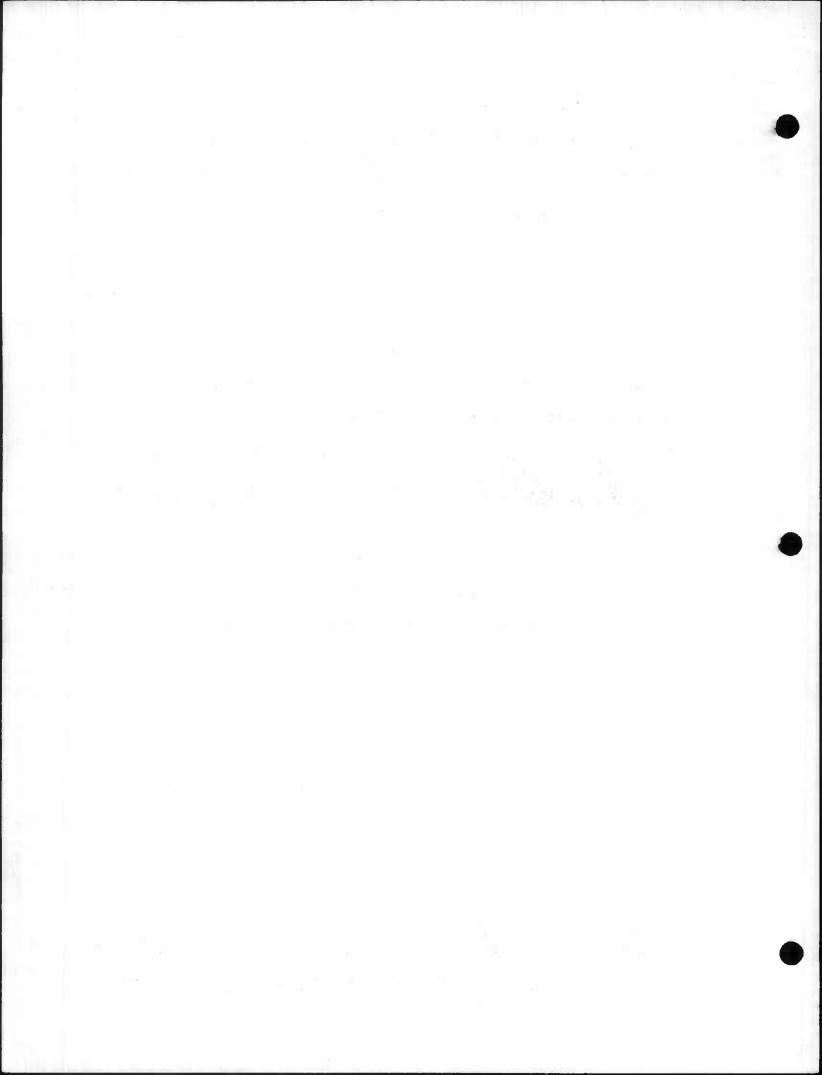
| Medical Example: On the basis of examplation and/or investigation, in my opinion, deeth occurred at the time, dete end piece, end due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sept 8th 1997 037949 30. And emaga address for position for complying country of dental (Union 234) (Type, Print) , my Elders hum 31. Date filed (Month, Day, Year) Registrar's Signature State Davidson-Randall SEP 1 0 1997 Registrar

Political and the second of th 8 4 5 55 . and provide the first first first than the first of the second state of the second sta

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 27413

| | | | | (| Certifica | ate of | Death | F | Reg. No. | T bo | . / . / 0 |
|--|----------------|--|--|---------------------------|--|--------------------------------------|---|---|------------------------------------|----------------------------------|--|
| Dhua | lalan | 1. Decedent's Neme (First, Middla, La | | | | | | 2. Dete of Dee Month | th | Vene | 3. Tima of Death |
| Phys /Me | dical | ROLAND | Ku | mmel | ζ | | | SEPTEMA | BER 4 | 1997 | 12:05 PM |
| | niner | 4e. Fectility Neme (If not institution, give | e street end number) | | | | 4b. City, Town, or I | ocation of Death | 4c. County | of Deeth | - 1 |
| | | the Johns Ho | PKINYTUSP | ital | | 16 | 3alt mor | e city | N/A | | |
| Funer Direct | | 5. Sociel Sacurity Number 6. 9 215-39-9810 | Sex 7. Age (In | yrs. last birth | Month | er 1 Yaar | | 8. Data of Birth (Month, Dev | Year) 5,1993 | Count | leca (Steta or Foreign try) yland |
| pu . | | Usual Residence of Decedent 10a. Stata 10b. County | 10 | c. City, Town | or t postion | | | | | | |
| e Manyla Ba-f shor | Director | | | Dung | | | | | | 10 | od. Inside City Limits 1 ☐ Yas 2 ☐ No |
| ath with the 23a or 2 | | 10e. Street and Number 407 Oakwood F | Rd. | | 10f. 2 | 212 | 22 | 1 | USA | /het Count | ry? |
| in all years of 12.12.13-0020 d2 should be filed within 72 hours efter death with the Maryland and Mental Hygiene. Z7 is marked other than "natural", or items 23s or 28s-f show traumatic event, as Medical Examiner must be notified a | by Funeral | 11. Marital Stetus 1 Never Merried 2 Marriad 3 Widowed 4 Divorced | 12. Wes Decedant Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: | r in U,S. | | edent of H ecify Cube 2][[] No | lispanIc Origin? (S en, Mexican, Puart Specify: | pecify Yas or No- o Rican, etc.) | 14. Race Blec Specify | e - America k, Whita, a Wh | |
| 72 h 72 h | Completed | 15. Decedent's E (Specify only highest gre | ducation | 18e. D | ecedent's Us | ual Occup | etion during most of war | kina | 16b. Kind of Bu | siness/Ind | ustry |
| | d de | Elementery/Secondery (0-12) | College (1-4or 5+) | - ' | | use retired | during most of world) | ANI Y | 27/2 | | |
| e filed with Hygiene. other than | ် | 0 | 0 | | N/A | | | | N/A | | |
| ije de H | Be | 17. Fether's Neme (First, Middle, Last | | | | | | ne (First, Middla, I Bialec | | a) | |
| should be and Mentel marked o | P | Kenneth Brian | | | | | | | | | |
| | | 19e. Informent's Neme/Retetionship (Kenneth Kumme | | r 40 | Meiling Addre | ss (Street KWOO) | and Number or Ru d Rd. D | rai Route Number undalk | Md. 21 | State Zip 222 | Code) |
| | 8 | 20e. Method of Disposition 1 Burial 2 □ Cremetion 3 □ 4 □ Donation 5 □ Other (Specif | Removet from Stete | cemetery St. | oisposition (N cremetory of Stani: | eme of r other pleas Slau | s Cem. | Dete 9 – 6 | 20c. Location - Dunda | | vn, Stata |
| permit. Pa Departmen Important any injury | DUCE | 21 Signature of Funeral Service Licer | Elle Ja | | Conn | elly | ss of Facility Funera lers Po | l Home | Of Dui | ndal | k |
| Physicia | n | 23a Part Lefter the disease, or com hock of heart felture. List only | plicetions that daused the one ceuse of each line. | deeth. Do no | t enter tha m | ode of dyin | ng, such es cardiac | or respiretory em | est, | | Approximate intervel Between Onset and Deeth |
| /Medica Examine | al | Immediata Ceuse (Final disease or condition resulting in deeth) | · Live | | | | | | |) | rous |
| ted nsit | Examiner | | b. Porta | to (or es e co | E IN | | on bosi. | 5 | | 1 | nonths |
| certificate be executed ding physiclen end se es the burial-transit | Medical | Sequentielly tist conditions, if eny, leeding to immediate causa. Enter Undarlying Cause (Disaese or Injury that initieted events resulting in deeth) Last | . LIVER A | to (or es e co | nALL 1 | 30W 8 | L Tran | splant | | | |
| death cert death cert e ettanding | clar | D. H. Oh I. W | | | | | | 1 | | | |
| d by th | Physician/ | Pert II. Other significant conditions of | ontributing to death but no | ot resulting In t | he underlying | cause giv | en in Pert i. | 23b. Did to | 1/ | | the cause of death? ably 4 Unknown |
| requiim been sign should be | Completed by | | | | | | | 24a. Was a perfor | | con | re autopsy findings illable prior to npletion of cause leath? |
| Physician: The lar this certificate has real director, page 2 | E O | | | | | | | 1 🗆 Y | es 2 No | | Yes 20 No |
| certificate rector, pag | BeC | 25. Wes case referred to medical | | | | | 26 Place of Dee | th (Check only or | | | 165 200110 |
| Physician: The ill this certificate ha | 10 8 | examiner? 1 ☐ Yes 2 ☑ No | Hospitei: | 2□ ER/Outp | atient 3 [| Oth Oth | Ar: | oma 5 Raside | - | e (Consile | 3 |
| Phys eral di | Ë | 27. Menner of Death | 28e. Dete of Injury | 28b. Tir | ne of | 28c. Injur | | 28d. Describe h | | | / |
| Attending ir death. ector: After by the fune | atio | 1. ■Neturel 5 Pending 2 Accident investigation | (Month, Day Ye | ar) Inji | ury M | | k? Yes 2 ☐ No | | | | |
| or Attending is efter death. Director: After d in by the fune | Certification: | 3 ☐ Suicide 8 ☐ Could not b 4 ☐ Homicide determined | e 28e. Pieca of Injury - building, etc. (S | | n, street, facto | ory, office | | 28f. Location (Si City or Town | | er or Rurel | Route Number, |
| To the Hospital or Attending Phwithin 24 hours efter death. To the Funeral Director: After this completely filled in by the funeral | edicai (| 29a. Certifier 12 Cartifying Ph (Check only one) | ysician: To the best of my niner: On the basis of exe end menner steted. | knowledge, omination end/ | feeth occurre or investigation | d et the tin | ne, dete end plece, pinion, deeth occur | , end due to the c rred et the time, d | ause(s) and me ete end piece, e | nner es ste and due to | eted. the cause(s) |
| To the within To the | M | 29b. Signature and title of certifier | 00 | _ | - | 9c. Licans | | | 9d. Date stgned | | |
| | | > Sleve /- | ald | _ | | B64 | 1976811 | 5 | EPTEMB | ER L | 1 1997 |
| | | 30. Name and address of person who | completed cause of deetn | (item 23e) (T | ype, Print) | | | | | | 1, 1997 e, MD |
| , | | STEVE GOLDI | | .1 | the J | ohns | Hopkins | Hospita | 1, Bal | hmor | e, MO |
| 5 | State | 31. Dete filed (Month, Day Yeer) | M.D. Ph Lukis Devirlois | Signingali | | | | 1 1 | - 6. | 4.40 | M |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9.7

| | | | | State of IVI | arylariu | | tificate of | | a Mental Hy | Reg. No. | 1 4 | 1414 |
|------------|---|---------------|---|--|-----------------|--------------------------|---|------------------------------------|--|--------------------------------------|-----------------------------------|---|
| т | Dhuele | | 1. Decedant's Nama (First, Middla, I | ast) | - | | | | 2. Dete of D | aath | Voor | 3. Time of Death |
| | Physic /Medi | | Alice Agnes H | King | | | | | | mba 8 | 1597 | 4 AM |
| | Exami | | 4a. Facility Nama (If not Institution, g | iva street and number) | | | | 4b. City, Town, | or Location of Dea | | y of Deeth | |
| | | | 4805 Torpoint F | Road | | | | Perry I | Hall | Balt | imore | |
| 1 | Funeral | | | | a (In yrs. last | t birthday) | if Under 1 Yeer | if Under 24 | | | | e (Stete or Foreign |
| | Director | | 212-09-2609 Usuel Rasidance of Dacedent | 1□M 2XF 82 | 2 | Yrs. | Months Days | Hours N | Septemb | lay, Year) 23,1914 | Maryl | and |
| | and will | | 10a. Stata 10b. County | | 10c. City, T | own or Loc | cation | | | | 10d | inside City Limits |
| | lanylan show | 5 | Maryland Baltimo | ro | Perry | | | | | | 100. | 1 ☐ Yas 2 ☑ No |
| | 10 N | Directo | V | 71 6 | 1 CITY | Hall | | | | | | |
| | £ 6 | ă | 10e. Street and Number | _ | | | 10f. Zip Code | | | 10g. Citizen of | | ? |
| | 13 F | - Ca | 4805 Torpoint Roa | ıd | | | 21236 | | | United | States | |
| | de Fil | Funeral | 11. Maritei Status | 12. Wes Decedant Armed Forcas? | Evar in U,S. | 13. V | Vas Decedant of I | Hispanic Origin | (Specify Yes or Nuarto Rican, etc.) | o- 14. Re | ce - Amarican ack, White, etc | |
| 21215-0020 | s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiena. Itam 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Experient must be notified at | by Fu | 1 ☐ Navar Married 2 🕱 Merried 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yas 2 🕱 If Yas, Giva Yeer or Detas: | | | ☐ Yas 2 🔀 No | | , | Speci | | |
| 9 | 2 hor | 8 | 15. Decedent's | Education | 1 | 6a. Deced | ent's Usuai Occu | oation | | 16b. Kind of E | Business/Indus | itry |
| 15 | 7 0 | Completed | (Specify only highest g | rada complated) | | (Giva I lifa. D | kind of work dona OO NOT usa retire | during most of | working | | | |
| 212 | filed within Hygiena. Wher than | E | Elamantary/Secondery (0-12) | Collaga (1-4or : | | lomema | | | | Own Ho | me | |
| D | H H H | | 17. Fethar's Nama (First, Middla, Las | st) | | TOMICING | anci | 18. Mothar's | Nama (First, Middle | | | |
| an | 2 should be and Mental is marked o | Be | John Glover | | | | | Louis | e Schuck | | | |
| 2 | d Me | 2 | | CE - To D. C. II | | 400 14 10 | | | | | | |
| Maryland | le c | | 19a. intormant's Name/Ralationship | | | | | | Rural Routa Numi | _ | | |
| | of Haalth Itam 27 I | | William H. King | Husband | | | Torpoint | RUdu | Perry Hal | | | 21236 |
| Baltimore, | | | 20a. Mathod of Disposition 1 ☑ Burlai 2 ☐ Crametion 3 | | cema | atary, cram | sition (Name of latory or other ple f Faith | , | Dete 11,1997 | | - City or Town | |
| === | 그는문을 | | 4 Donation 5 Other (Spec | ** | | | | | a 11,1337 | Darcini | ore, ric | ii y tana |
| Ba | permit. Pege Department of Important: If any Injury or once. | | 21. Signeture of Funeral Service Lic | The state of the s | Zavoyr | rec | onard J. 05 Harfo | Ruck. | Inc. Baltimo | ore, Mar | vland | 21214 |
| | | | 23a. Part1. Entar tha diseesa, or con shock, or haart fallure. List onl | mplications thet caused | tha death. [| 1 | | | | | A | pproximata tarval Between |
| | Physician /Medical Examiner | Examiner | Immediata Cause (Finel disease or condition resulting in death) | a Hyperte | Due to (or as | a consequ | 15- | otic Ca | rdio | | | |
| 68760, | ficate be executed physician and as the burial-transit | edicai Exar | Sequentially list conditions, if any, teeding to immadieta causa. Entar Underlying Cause (Disaase or Injury that initiated evants | c | Due to (or as | | | | | | | |
| Box 68 | death certifica e attending ph id for usa as th | Physician/Med | rasulting In death) Lest | d | | | | | | | | |
| | death he atte | Cla | Part It. Other significant conditions | contributing to death b | ut not resultin | o in the un | darlying cause of | ven in Part i | 23h Dio | I tobacco use co | ontribute to th | e cause of death? |
| P.0 | 6 4 4 | hya | | outing to double b | ar rior roomin | g iii ala aii | dairy ang dadaba gi | von mit anti. | | Yes 2 No | | oly 4 🖸 Unknow |
| | med to | | | | | | | | _ | 7144 20140 | 0 1 1 10000 | ny v _j ajonialom |
| cords, | P | Completed by | | | | | | | | s an autopsy formed? | avalla | autopsy tindings ble prior to letion of causa ath? |
| Œ. | 1 124 | E | | | | | | | 10 | Yas 2 No | 100 | es 2 No |
| tal | T and | | 25. Was casa retarred to medical | | | | | 26 Dines et | Death (Check only | SOUTH AND ASSESSED. | | 2010 |
| Vital | sicia cont frect | o Be | axaminar? 1 ☑ Yas 2 ☐ No | Hospitel: | OFD | /O. 4N | Ott DOA Ott | hor | | | | |
| ō | Phys Phys Parid | H | 27. Manner of Deeth | 28a. Data of Inju | nt 2 ER | b. Tima of | 3LI DOA | 4 LI Nursin | g Homa 5 X Res | how Injury occu | | |
| On | Attending at deeth. | tion | 1 Netural 5 Panding 2 Accident invastigati | (Month, De | y Year) | tnjury | 28c. Inju Wo | rk? Yas 2 □ No | 200. 20001120 | non injury cood | | |
| 2 | deeth. ctor: A y the fu | cal | 2 Accident Invastigati 3 Suicida 6 Could not | be | | | | Tas ZUNO | 004 1 1 | /644 to 4 to 1 | | |
| Division | after deeth Director: A | ertification: | 4 ☐ Homicida datarmine | bullding, at | | , tarm, stre | et, factory, office | | | (Street and Num own, Stete) | ber or Hurai H | outa Number, |
| | urs of the leaf | O | | | | | | | | | | |
| | To the Hospital or Attent within 24 hours after deet To the Funeral Director: completely filled in by the | edical | 29a. Certifiar (Check only one) 1 ☐ Certifytng P 2 ☑ Medtcal Exa | hystcian: To the best of miner: On the basis of and manner sta | axamination | dga, daath and/or inv | occurred at tha ti astigation, in my o | me, dete and pi pinion, daath o | ace, and dua to the ccurred at tha tima | a cause(s) and m , data end place | annar as state , and dua io th | ed. a causa(s) |
| | To the within 2 To the comple | ž | 29b. Signature and title of certifier | | | | 29c. Licens | se number | | 29d. Date sign | ed (Month, Day | y, Year) |
| | ->-0 | | 111 | | _ | 1 | 1 | ma- | 63 | 7-5 | , , | 1000 |
| | 0 | | Marles | 1 42 | m | rell | 1400 | 7093 | 000 | Kem | bary, | 1797 |
| | | | 30. Nema and address of person who | | | | | | 00 0 11 | / | | 04046 |
| | | | Charles F. O'Don | | | | ыттт коа | u ste.4 | 08 Baltin | nore, Mar | yrand | 21210 |
| | Sta Registr | - 1 | 31. Data tiled (Month, Day, Year) SEP 1 0 1997 | Full Sa | ar's Signatura | andett | sia a | | | | | |

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene 97

97 27415

| | | | | | | | Cer | tificate o | t Death | | | Reg. No. | | | |
|--------------------------|---|----------------|--|---------------------|----------------------|------------------------|---------------|------------------------------------|------------------|----------------|---------------------------------|-------------|----------------------------|-----------------------------|---------------------|
| | Discorte | | Decedant's Name (First, Mice | ddia, Last) | | | | | | | 2. Date of De | | Vaar | 3. Tim | a of Death |
| | Physic | | JOHN FRA | NCIS | KET.T.V | 7 CD | | | | | Month Septem | Day | Yaar | | 40 AM |
| | /Medi Exami | | 4a. Facility Name (If not institut | | | SR | | | 4b. City, Tov | vn, or Lo | cation of Death | | county of Deat | | 40_AM_ |
| ч | LAGIIII | IICI | | La Company | | | | | _ | | | | | | |
| Н | - | | Edenwald Cent 5. Social Security Number | er 6. Sax | 7 4 | ge (In yrs. lest bii | rthday) | If Under 1 Yea | | WSOI 4 Hrs. | 8. Date of Bir | | Baltim | | to as Causian |
| | Funeral | | o. Social Social y Humbar | 1 □X M 2□ | | | Yrs. | Months Day | | Min. | (Month, De | y, Year) | | | te or Foreign |
| | Director | | 213-09-7305 Usual Residence of Decedent | | | 89 | | | | | June 2 | , 190 | 8 Was | hingt | on D.C. |
| | P ≥ _ | | 10a. State 10b. Cour | ntv | | 10c. City, Tow | n or Loc | cation | | | | | | 10d Ineid | e City Limits |
| | ahow | 5 | | | | , | 111 | | | | | | | | res 2⊠ No |
| | 9 P | S S | | ltimore | | T | owsc | | | | | | | | 00 1120110 |
| | £ 8 | Director | 10e. Street and Number | | | | | 10f. Zip Code | | | | 10g. Citize | en of What Co | untry? | |
| | 23° | <u>e</u> | 800 Southerly | Rd. #21 | 6B | | | 21 | .286 | | | | USA | | |
| | ep L | Funeral | 11. Marital Status | 12. Was | Decedent d Forces | Ever in U,S. | 13. W | Vas Decedent of Yes, specify Cu | Hispanic Orlg | In? (Sp | ecify Yas or No Rican, etc.) | - 14 | Race - Ama Black, White | | 1. |
| 0 | or it | | 1 ☐ Never Married 2 🔀 M | arried 1 🗆 Y | es 2 🔀 | | | ☐ Yes 2 N | | | | | | 5, 610. | |
| Maryland 21215-0020 | be filed within 72 hours efter death with the Maryland ttal thygiene. Id other than "natural", or items 23a or 28a-f ahow event, the Medical Exeminet must be notified at | by | 3 ☐ Widowed 4 ☐ Divorce | ed Yaar | or Dates: | | | 103 ZW | о зрасну. | | | 3 | Specify: W | hite | |
| 5-0 | 72 h | Completed | 15. Deced | ent's Education | tod) | 16a. | Deced | ent's Usual Occ | upation | as wast | ina | | of Business/ | | |
| 21 | | pie | Elementary/Secondary (0-12 | hast grade comple | ge (1-4or | 54) | life. D | kind of work don O NOT use reti | red) | OF WORK | ing | Cons | olidat | ea | |
| 2 | filed within Hygiene. ther than | PO | Elonionally Couplingly (o 12 | | 5+ | - | ecut | cive Pre | sident | | | Deli | very C | ompan | У |
| D | a de la | BeC | 17. Father's Name (First, Middl | le, Last) | | | | | 18. Mother | r's Name | e (First, Middle, | Maiden S | umeme) | | |
| a | d 2 should be filed within th and Mental Hygiene. 7 is marked other than traumatic event, the Me | ToB | Tohn | Mh om | | 17.0 | 11 | | M= | | | | Dina 1 | a | |
| 5 | d 2 should th and Men 7 is marks traumatic | - | John 19a. Informant's Name/Retatio | Thom | | | 11y | g Address (Stre | Mary | | al Route Numb | or City or | Donal | | |
| M | d 2 s | | | | | | | | | | | | | .ip Could) | |
| | | | Mr. Keiren O. | Kelly\20 | n | | | Falls Graltion (Name of | cove wa | y Fa | Date | - | 2104 / | T 01-1 | |
| Ö | Ses Total | | 1 Burial 2 Cramation | n 3 🗆 Removal f | rom Stata | anmoto | ry, crem | atory or other p | lece) | i | Date | 20C. LOCE | ation - City or | rown, State | , |
| Baltimore, | permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once. | | 4 □ Donation 5 □ Other | (Specify) | | Dulane | y Va | alley Me | morial | . ! 9 | 9/11/97 | Tim | onium, | Md. | |
| a | Depart Import any in | | 21. Signature of Funeral Sarvio | a Licensee | | | | Name and Add | | | I II ama | T | | | |
| • | 89789 | | 1 subset | 753/1/2 | - | | | ick Tows | | | | | 4 | | |
| | | | 23a. Part1. Enter the disease, shock, or haart failure. Li | or complications t | hat cause | d the death. Do | not ente | 050 York or the mode of d | ying, such as | cardiac o | or respiratory a | rrest. | 4 | Approxi | mate |
| | Physician | | shock, or haart failure. Li | ist only one cause | on each i | ine. | | | | | | | į | Onset a | Between nd Death |
| | /Medical | | Immediate Cause (Final | | 1 | L Ma | | 1. 1 | TO | | 15 | | | -) | |
| | Examiner | | disease or condition resulting in death) | a | Acn | te My | o Ca | rdial | Inta | irc | tion | | | Zho | urs |
| | | 5 | | | | Due to (or as a | consequ | uence of): | | | | | | | |
| | ed sit | Examiner | | b | امان | Due to (or as a on ary | Ar | tery D | iseas | 2 | | | | 1046 | ars |
| | certificate be executed iding physician and ise as the buriel-transit | Kan | Sequentially list conditions, | | | Due to (or as a | consequ | uence of): | | | | | | | |
| 68760, | se ey | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury | J | | | | | | | | | | | |
| 87 | hysi the t | dice | that tritiated events resulting in death) Last | | | Due to (or as a | consequ | ence of): | | | | | | | |
| 9 | ing p | Medical | | | | | | | | | | | | | |
| Box | - 5 - | an | | d | | | | | | | | | | | |
| | the death by the atte | Physician | Part II. Other elgnificant condi | tione contributing | to death b | out not resulting in | n the un | derlying cause of | given in Part I. | | 23b. Did | tobacco us | se contribute | to the cau | se of death? |
| P.0 | t the | h y | ^ | | | | | | | | 1□ | Yee 2 🗆 | No SUZPI | obably 4 | I □ Unknown |
| -5 | 1 | by F | multiinfan | ct Demo | ntic | 1 | | | | | | - 3 | | , | |
| ğ | (PA) | | Sick Sinus | 0 | | | | | | | 24a. Was | an autops | y 24b. 1 | Were autop | sy findings |
| 8 | 81 13 | Completed | Sick Sinus | Syndi | rom | €. | | | | | | rmed? | | available pri complation | |
| ž | | du | | • | | | | | | | | | (| of death? | |
| = | The sate h | S | | | | | | | | | 101 | Yes 2 | No 1 | □ Yes | 2□ No |
| /II | Physician: The this certificate and director, par | Be | 25. Was case referred to medic examiner? | | | | | | 28. Place | of Deat | n (Check only o | one) | | | |
| = | W 10 | 2 | 1 ☐ Yes 2 No | Hospital: | 1 🗆 Inpati | ent 2 ER/Ou | stpatient | 3□ DOA | Other: 48 Nur | sing Ho | me 5 Resid | dence 6 l | Other (Spec | cify) | |
| Division of Vital Record | ding Phy h. After thi funeral | | 27. Manner of Death 1 ☑Natural 5 ☐ Pend | | ate of Inju | | Time of njury | 28c. Inj W | ury at | | 28d. Describe I | how injury | occurred | | |
| 0 | Attending or death. ector: After by the fune | Certification: | | stigation | | , | injury | | JYes 2□N | 10 | | | | | |
| Vis | or Attendation of Director: | ific | 3 ☐ Suiclde 6 ☐ Coul 4 ☐ Homicide dete | mined 286. F | laca of In | ury - At home, fa | rm, stre | et, factory, offic | a | | 28f. Location (| | Number or Ru | rel Route A | lumber, |
| ā | after A Direct din by | ert | 4 LI Homicide | | uilding, et | c. (Specify) | | | | | City or Tov | vn, Stete) | | | |
| | Hospital 24 hours Funeral stely filled | | 29a. Certifier 1 Certify | ring Physician: To | the best | of my knowledge | death | occurred at the | time, date and | place. | and due to the | cause(s) a | nd manner as | stated. | |
| | Mospital 24 hours Funeral letely filled | edical | (Check only 2 Medical one) | al Examiner: On the | ne basis o | f examination an | d/or Inve | estigation, in my | opinion, deat | h occurr | ed at the time, | date and p | laca, and due | to the caus | e(s) |
| | To the Mospital or At within 24 hours after of To the Funeral Direct completely filled in by | Me | 29b. Signature and title of smill | 1 | 1 | | | 29c. Lice | nse number | | | 29d. Date | signed (Monti | h, Dey, Yea | r) |
| | - > - 0 | | 2</td <td>1.) \///</td> <td>14</td> <td></td> <td></td> <td>*</td> <td>2/// 21</td> <td>/</td> <td></td> <td></td> <td></td> <td></td> <td>-1.1</td> | 1.) \/// | 14 | | | * | 2/// 21 | / | | | | | -1.1 |
| | 110 | | 100 | 100 | | | | | 34/24 | | | | 7-8-9 | | |
| | (() | | 30, Name and address of person | n who completed | | /h | 1 1 | Print) | 1 | | MD. | | | | |
| | 14 | | John D./1/1 | HO WD | 1 70 | ,00 US/ | ers) | 1 F311 | 10WS | on, | IND. | 212 | 04 | | |
| | Sta | | SEP 1 0 1997 | 31 | 2. Registr | ar's Signature | . 04 | | | | | | | | |
| | Registi | ar | API T 0 1931 | 1 | | Hala - Marle | CALCO. | | | | | | | | |

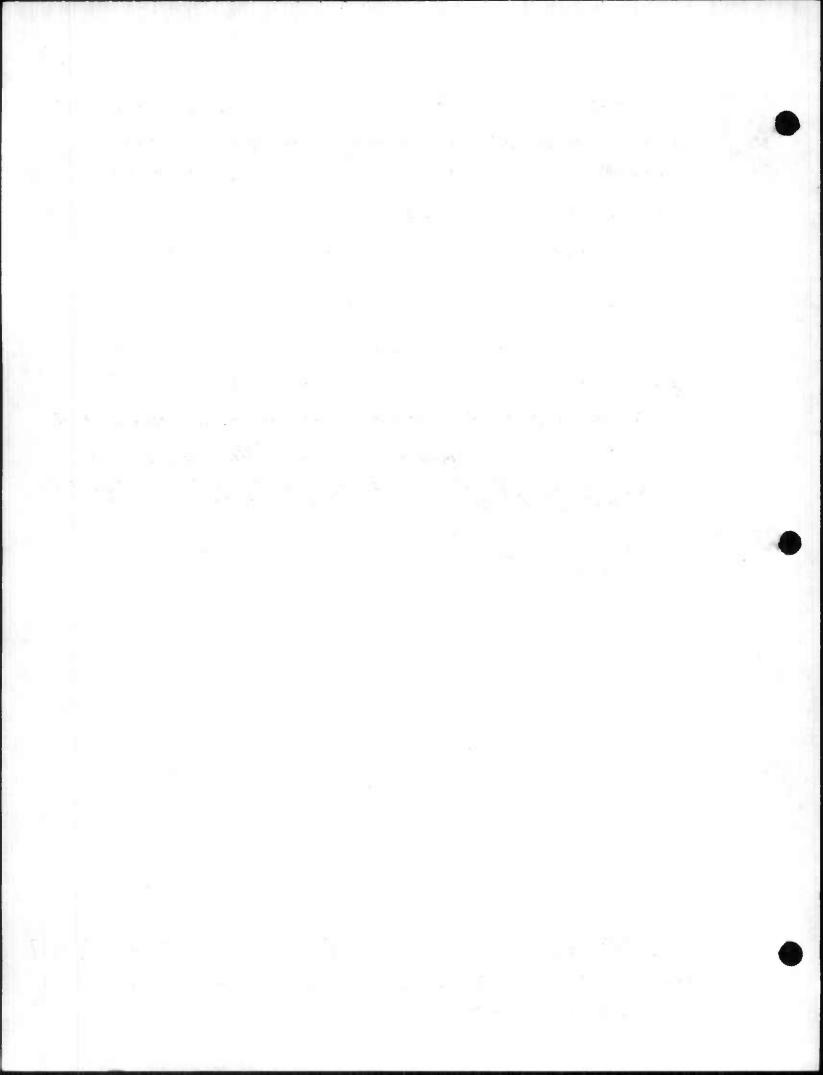
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State of Maryland / Department of Health and Mental Hygiene 97 274 16

| | | | | | rtificate of | Death | | Reg. No. | - 6 1 | 710 |
|--|---------------------|---|--|---------------------------------|---|---|---|-----------------------------------|--|---|
| Physic | ian | 1. Decedent's Name (First, Middle, I | | Keen | | | 2. Dete of De Month | Day | Year 3. | Time of Deeth |
| /Medi Exami | | 4e. Fecility Neme (If not institution, o | | 1/6611 | | 4b. City, Town, or L | ocation of Deeth | | of Deeth | 1838 |
| LAGIIII | iei | University of | Maryland He | edicals | Sustem | Rait | more | 1 |)/A | |
| Funeral Director | | 220-22-3089 | Sex 7. Age (In yrs. 1 M 2 F 71 | last birthday) Yrs. | If Under 1 Year Months Deys | If Under 24 Hrs. Hours Min. | 8. Dete of Birt (Month, Da Feb. 1 | | 9. Birthplece Country) Balto, | (State or Foreign |
| and | | Usuel Residence of Decedent 10e. Stete 10b. County | 10c Cit | y. Town or Lo | ocation | | | | 104 1 | anida Cita t imita |
| Marylan -f ehow | tor | | | thicum | | | | | | nside City Limits |
| or 28a-f | irec | 10e. Street end Number | | | 10f. Zip Code | | | 10g. Citizen of | Whet Country? | |
| 23a c | ral | 15 Mansion Road | 3 | | 210 | 90 | | USA | | |
| filed within 72 hours after death with the Maryland Hygiene. Hygiene there were need to notified a net, me Medical Examine met be notified a | by Funeral Director | 11. Maritel Status 1 □ Never Merried 2 □ Married 3 □ XWidowed 4 □ Divorced | 12. Wes Decedent Ever in U, Armed Forces? 1 ☐ Yes 2∑No If Yes, Give Yeer or Dates: | | Was Decedent of Information of Info | tispantc Origin? (Sp en, Mexican, Puerto Specify: | ecify Yes or No- Ricen, etc.) | | e - American Ir ck, White, etc. w: White | ndian, |
| 72 hours naturel', | eted | 15. Decedent's l (Specify only highest g | | 16e. Deced | dent's Usuel Occup | petion during most of work d) | rina | 16b. Kind of B | usiness/Industr | у |
| within one. than " | Completed | Elementary/Secondery (0-12) | College (1-4or 5+) | | | d) | y | Home O | mor | |
| should be filed within to Mental Hygiene. marked other than imatic event, me M | | 12 17. Fether's Neme (First, Middle, Las | U | Homem | aker | 18. Mother's Nam | e /First Middle | | | |
| Mentai I Mentai I arked of | To Be | Boyd A. Holt | * | | | | . Noone | maiddir Dairion | | |
| C/ g = 0 | | 19e. Informant's Neme/Reletionship Carol Keen (Da | (Type, Print) aughter-in-law) | | | and Number or Run ford Mill | | | | |
| es 1 and of Health filam 27 r other t | | 20e. Method of Disposition 1 Danial 2 Oceremetion 3 | 20b. P | Plece of Dispo | sition (Neme of netory or other pla | ce) | Sept 8 | 20c, Location - | City or Town, | Stete |
| . Pages Iment of I tant: If its jury or or | | 4 Donetion 5 Other (Spec | Puellinael Holli Stefe | een Mo | unt Ceme | tery | 1997 | Baltimo | | |
| permit. Page Department o Important: If i any Injury or ance. | | 21. Signature of Funeral Service Lice | ensee | 22 | Name end Addre | olyniak F rt Ave., | uneral | Home of | South | Balto. |
| 40390 | | Hannel C | V. Maylor | | | | | | 21230 | |
| Obveision | | 23e. Pert1. Enter the disease, or con shock, or heart feilure. List onl | mplications thet caused the deeth y one cause on each line. | n. Do not ent | er the mode of dyli | ng, such es cerdlec | or respiretory er | rest, | Inte | roximete rvel Between set end Deeth |
| Physician /Medical | 8 | Immediete Ceuse (Final diseese or condition | · Bilate | cal | Carnt | id Act | CII Ma | alusi o | | |
| Examiner | | resulting In deeth) | e. Due to (o | r ac a concen | llopoo of). | | | C143101 | | |
| po ÷s | ine | | Cerebra | Va | scular | acci | dent | | | |
| cate be executed physician and sthe buriel-transit | Examiner | Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury | | res e conseq | uence of): | | | | | |
| rificate be executed ng physician and es the burial-transit | | Ceuse (Diseese or injury that initieted events | V | | erosis | | | | i | |
| 5 0 6 | Physician/Medical | resulting in deeth) Lest | Due to (or | r as e conseq | uence of): | | | | | |
| attendin for use | an/N | | d | | | | | | | |
| 0 0 0 | /sici | Pert II. Other eignificant conditions | contributing to death but not resu | ulting In the ur | nderlying cause giv | ren in Pert I. | 23b. Dld te | obacco use co | ntribute to the | cause of death |
| that the dended by the a | | | | | | | 101 | ree 2□No | 3 Probably | 4 Unknow |
| 0 50 | d by | | | | | | 24a. Wes | en eutopsv | 24b. Were a | utopsy findings |
| s been si should | Completed | | | | | | perfor | med? | aveilebl | e prior to tion of ceuse |
| te hes | E O | | - | | | | 1DY | es 21ANo | 1 🗆 Yes | |
| s certificate he director, page | Be C | 25. Wes cese referred to medical | | | | 26. Plece of Deet | | | | -7.10 |
| Physic rthis ce ral dire | To | exeminer? | 1 | ER/Outpetien | t 3 DOA Oth | er: 4 Nursing Ho | me 5 Resid | ence 6 DOth | er (Specify) | |
| 5 6 6 | ion: | 27. Menner of Deeth 1 Netural 5 □ Pending | 28e. Dete of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injur Wor | | 28d. Describe h | ow injury occur | red | |
| al or Attending s efter death. Il Director: After ed in by the fune | licat | 2 Accident Investigation 3 Sulcide 6 Could not l | 00 51 111 | me form etre | | Yes 2 □ No | 28f. Location (S | treat and Numb | er or Purel Pou | ito Number |
| ofter Direction b | Certification: | 4 ☐ Homicide determined | building, etc. (Specify | () | set, factory, office | | City or Tow | n, Stete) | er or Hurar Hoc | ite raditiber, |
| within 24 hours efter To the Funeral Director Completely filled in t | edical C | 29a. Certifier (Check only one) Certifying Plant Certifying Certifying Plant Certifying | nyelclan: To the best of my know miner: On the basis of examinet and marriner steted. | vledge, deeth ion end/or Inv | occurred et the tir restigation, in my o | ne, dete end plece, pinlon, deeth occuri | end due to the cred et the time, c | ause(s) end me late end plece, | nner as steted | ceuse(s) |
| withir To th | M | 29b. Signature and ties of ospiner | | | 29c. Licens | e number | 2 | 9d. Dete signe | (Month, Dey, | Year) |
| - 3 F 3 | | | | | _ | | | | | |
| F3F8 | | 1/14//// | | | PI | 1195 | 4 | Septem | ber o | 5,1997 |

DHMH 16 Rev 6/95

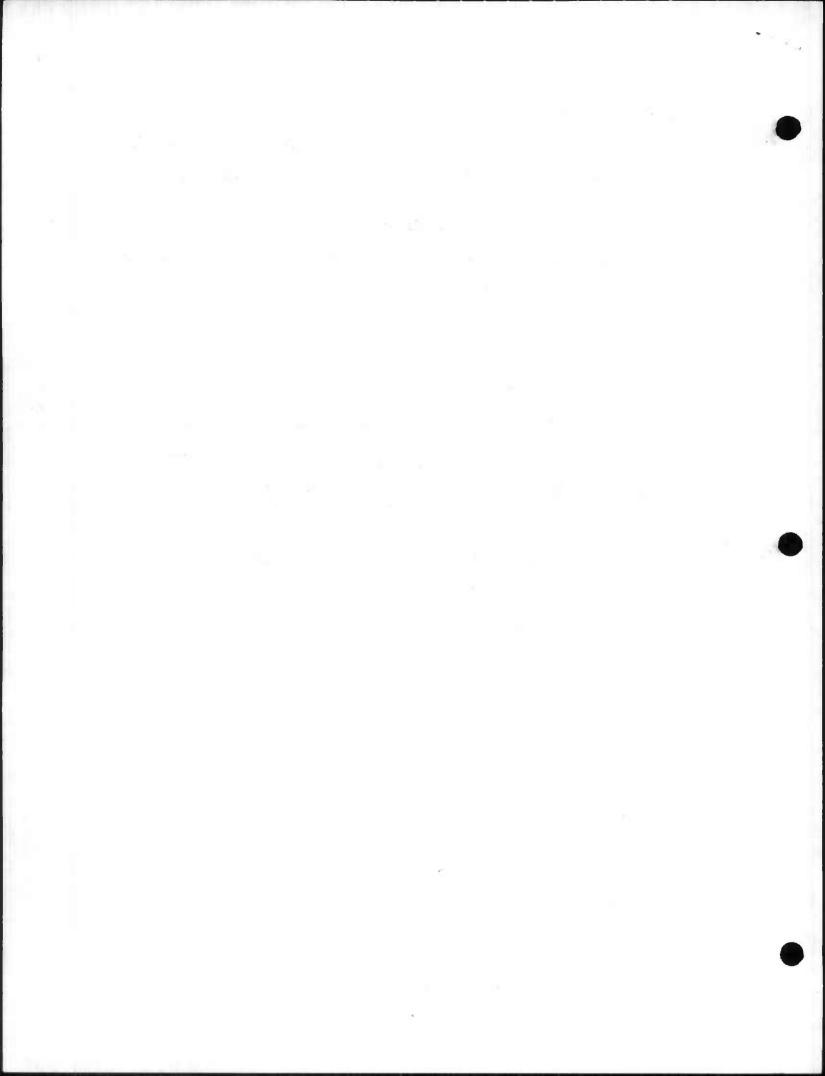
State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | | | | | Certificate of | Death | | Reg. No. | | |
|----------------------------|--|---|--|---|--|--|--|--|--|--|--|
| | | | 1. Decedent's Name (First, Middle, I | Last) | | | | 2. Data of D | eath | | 3. Time of Death |
| | Physic /Medi | | EUN HYO K | in | | | | Sels | Day | Year | 12:40 AM |
| ш | Exami | | 4a. Facility Name (If not institution, g | riva street and number) | | | 4b. City, Town, or | Location of Deal | | | 10. |
| 1 | | | PAROR LARS | - RUXTO | 0 | | RUXTOR | | BALT | inores | |
| | Funeral | Г | | Sex 7. Age (/ | In yrs. last bir | thday) if Under 1 Yaar Months Days | If Undar 24 Hrs | 8. Date of Bi | rth av. Year) | 9. Birthplac | e (State or Foreign |
| | Director | | 22031 8028 | 12 M 2□F 85 | | Yrs. | 110013 | JAn. 1 | 1912 | SOUTH | KORSA |
| | pu * | | Usual Residence of Decedent 10a. State 10b. County | 11 | Oc. City, Tow | n or Location | | | | | In side City I imite |
| | 72 hours efter death with the Menfand neturel; or items 23s or 28s-f show ficel Exercise, must be political | ŏ | | | | | | | | 100. | Inside City Limits 1 ☐ Yes ② No |
| | the N | Directo | 10e. Street and Number | 1619 | raci | さんないこと | | | 40- Cid | 140-10 | |
| | with with | | | 0 | ^ | 10f. Zlp Code | | | 10g. Citizen of | | |
| | s 23 | Funerai | 1908 MUTULI | 12. Was Decedent Eva | () | | 030 | 2 | SOUTH | ce - Amarican | W. L |
| | iter d | S | 11. Marital Status 1 Nevar Married 2 Married | Armed Forces? | ar iii U,S. | 13. Was Decedent of I If Yas, specify Cub | an, Maxicen, Pue | to Rican, etc.) | | ck, White, etc. | |
| 20 | I, or | by F | 3 Widowed 4 □ Divorced | if Yes, Give Yaar or Datas: | | 1 ☐ Yes 2 No | Specify: | | Specify | Y.Y. O. | |
| 21215-0020 | "neturel", | 8 | 15. Decedent's | | 160 | Decedent's Usual Occup | pation | | 16b. Kind of B | NO12 | An |
| 715 | C * 6 | Completed | (Specify only highest g | rade completed) | | (Give kind of work done life. DO NOT use retire | during most of wo | orking | 100.74110.01.01 | 0011000111000 | , |
| 21, | | EO | Eiementary/Secondary (0-12) | College (1-4or 5+) | 2 | LEEMP. | -Owns | R | FURNT | 11183 | STORS |
| p | be filed at hygie d other | BeC | 17. Father's Neme (First, Middle, La. | st) | 90000 | 571.567 | | -1-3 | , Malden Surnan | | 4.015 |
| /बर | 0 0 0 0 | To B | Young So | on Kim | | | 10. | OL T | HO M | | |
| Maryland | S D E E | | 19a. Informent's Name/Relationship | | 19b | . Mailing Address (Street | | | per, City or Town, | State, Zip Co | ode) 21030 |
| | CHNF | | Yours R. K. | M | 12 | 08/JALNIT | COOUT | ROAD | Lecksyn | Teller | PARMANO |
| ore | | | 20a. Method of Disposition | | 20b. Place of | Disposition (Name of y, crematory or other pla | | Date | 20c. Location - | City or Town | , State |
| Baltimore, | 0==0 | | D⊠ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Space | | - 1 | RY VALLEY | , | 5297.12 | Timor | miir | marian |
| alti | permit. Pe Departmer Important: any Injury | | 21. Signature of Funeral Service Lie | ensae | CUAL | 22. Name and Addre | ess of Facility | 2:m: 42 | 111 101 | 11101 | 21093 |
| 8 | Depa Impo | | 1207 50 | and the | | ELAU? CA | SO TIGHT | V 111.00 | | 200 | 0100 |
| | _ | | 23a. Part1. Enter the disease, or co shock, or heert failure. List only | \mathbb{N} | a daath. Do i | not enter the moda of dyl | ng, such as cerdia | c or respiratory | arrest, | AC | proximate |
| | Physician | | shock, or heert failure. List on | ly one ceuse on each line. | | | | | | | terval Between nsef and Death |
| ш | /Medical | | immediate Cause (Final disease or condition | · LEREBR | 1201- | 1 01/10 | KCLDEN | Angeles . | | | |
| | Examiner | | resulting in deeth) | | ONN | ULLAIS | 16 (11) 12 | () | | | |
| | | See. | | Du | e to (or as a | | | | | 1 | |
| | 73 5 | ne | | | | consequence of): | | | | | |
| | cuted | amine | Sequentially list conditions, | 6. HYPERT | ENSI | consequence of): | | | | | |
| o, | e axecuted ian and unal-transit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b. HYPERT | ENSI e to (or as a | consequence of): | | | | | |
| 3760, | ate be axecuted hysician and he burial-transit | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | 6. HYPERT | ENSI e to (or as a o | consequence of): | | | | | |
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| | T | edical | that initiated events | 6. HYPERT | ENSI e to (or as a o | consequence of): | | | | | |
| Box | attanding for use ea | edical | that initiated events | b. MYPERT Due d. | EVS, e to (or as a o | consequence of): consequence of): consequence of): | | | tobacco use co | entribute to th | e cause of death? |
| Box | it the death certif by the attanding tached for use et | edical | resulting in death) Last | b. MYPERT Due d. | EVS, e to (or as a o | consequence of): consequence of): consequence of): | | 23b. Dld | tobacco use co Yas 2⊠No | | e cause of death? |
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Day **Physician** SADE KOSLOWSKI SEPTEMBER 7,1997 10:15 PM /Medicai 4a. Facility Nama (If not institution, give streat and number) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** 559 SHIPLEY ROAD LINTHICUM ANNE ARUNDEL If Undar 24 Hrs. Hours Min. If Under 1 Year 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Yaar) 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 KF Months Yrs. 297-18-9199 Director 74 MARCH 10,1923 OHIÓ Usuel Rasidance of Dacedani the Maryland 10b. County 10c. City, Town or Location 10d. Insida City Limits 25a-f show must be notified at Director MD ANNE ARUNDEL LINTHICUM 1 Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? flems 23a or 559 SHIPLEY ROAD 21090 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 11. Marital Status Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian Black, Whita, atc. hours after 1 Navar Marriad 2 Married 1 ☐ Yas 2 ☑ No If Yas, Giva Baltimore, Maryland 21215-0020 'natural', or 1 Yas 2 No Specify: þ Specify: 3 ☑ Widowed 4 ☐ Divorced WHITE Yaar or Datas: Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry filled within 72 Hygiene. Elamantary/Secondary (0-12) 12TH GRADE Collaga (1-4or 5+) CLERICAL STEEL MILL COMPANY permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyperant If Hem 27 is marked any Injury or other. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumema) Be MOSES COLCLOUGH JEAN MACKEY 2 19e. Informent's Name/Reletionship (Typa, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Steta, Zip Coda) EDITH M.COLCLOUGH (SISTER) 559 SHIPLEY ROAD - LINTHICUM, MD. 20b. Place of Disposition (Nema of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 9/11/97 BALTO NATIONAL CEMETERY BALTIMORE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fugural Service Licensee 22. Nama and Addrass of Facility HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE - BALTIMORE, MD 21229 ul. e disaasa, or complications that cabsad the deam art failura. List only ona causa on aach line. not antar the mode of dying, such as cardiac or respiratory arrest, Approximata Interval Batwean Onsat and Death **Physician** Immadieta Cause (Final disaasa or condition rasulting in daath) /Medical LUNG CARCINIUMA 6 MONTH Examiner Due to (or as a consaquence of): Examiner es that the death certificate be executed Sequantielly list conditions, if any, leeding to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initieted events rasulting in daath) Last pue -tran Dua to (or as a consequence of) ettending physician for use as the buriel Division of VItal Records, P.O. Box 68760, Physician/Medicai Dua to (or es e conseguança of) Part II. Other significant conditions contributing to death but not rasulting in the undarlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No þ 90 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Wes en autopsy page 2 shou performed 1 Yes 2 Miller 1 ☐ Yas 2 ☐ No Be 25. Was casa rafarrad to madical axaminer? 26. Plece of Deeth (Check only one) A Hospital or Atten.

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*al Director: Affer this

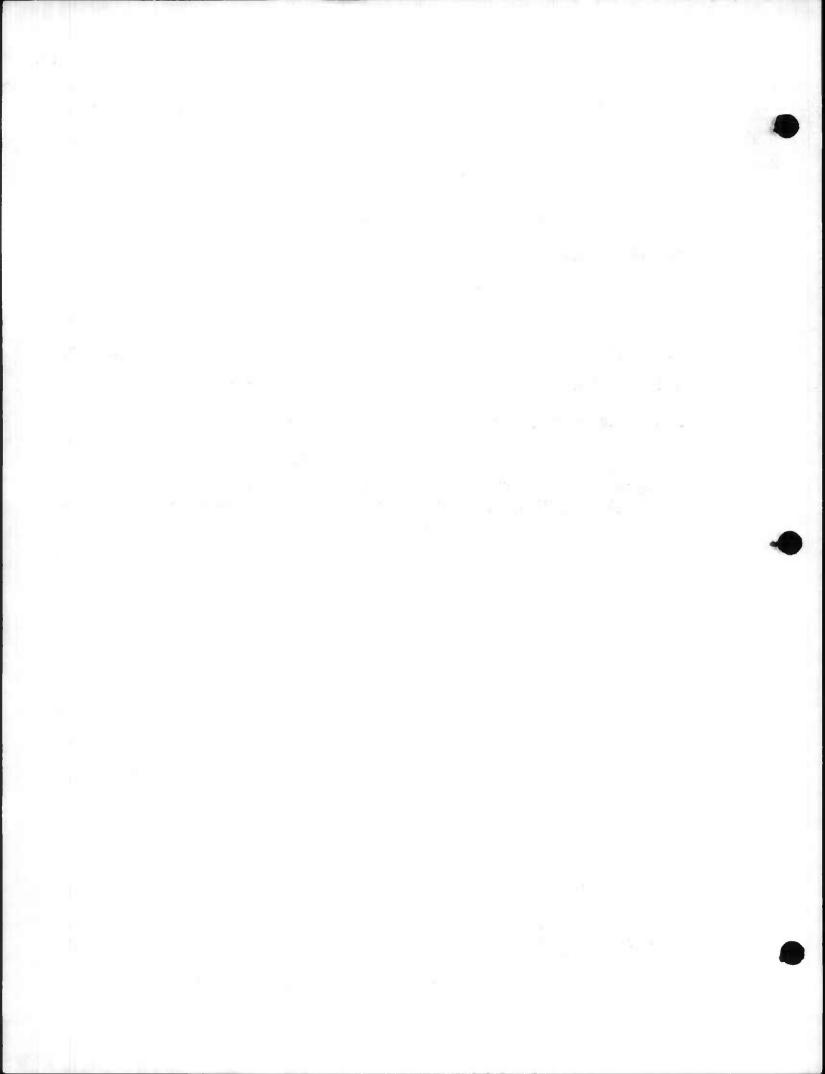
"a by the funeral dire Other: 4 Nursing Homa 5 Pesidance 6 Other (Specify) 1 Yas 2 No Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Deta of Injury (Month, Day Yaar) 28c. Injury at Work? 28b. Time of 28d. Dascribe how Injury occurred 5 Panding invastigation 1 Natural Injury 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not ba determined 3 Suicide 28f. Location (Straat and Number or Rural Routa Number, City or Town, Steta) 28a. Place of Injury - At home, ferm, straat, factory, offica building, atc. (Specify) 4 \(\text{Homicide} \) within 24 hours e To the Funeral C 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, death occurred at the time, data and place, end due to the ceusa(s) and mannar statad. edical 29a. Cartifier (Check only onel the 29b. Signatura and titla of cartifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) nauer.

State Registrar

DR. JOHN SHAVERS

518 S. CAMP MEADE ROAD - LINTHICUM, MD 21090 gistrar's Sight

30. Name and address of person who complated cause of death (Item 23e) (Typa, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 274 9

Certificate of Death

Reg. No.

2. Date of Deeth
Month
Day
Year
3. Time of Deeth
Month
Day
Year
4: 23PM

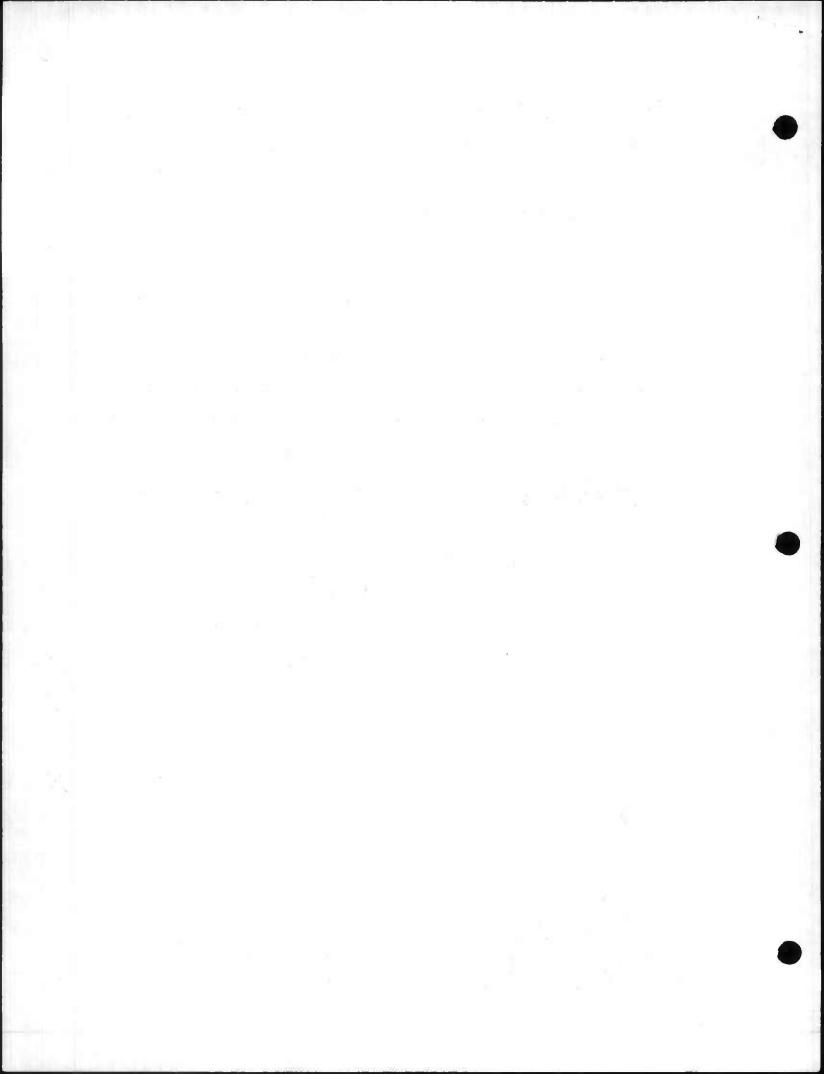
1 Decedent's Name /First Middle Last **Physician** George /Medical 4:23PM 4a. Facility Name (If not institution, give street end number, 4b. City, Town, or Location of Deeth 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE
If Under 1 Year | If Under 24 Hrs. 8, De N/A 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dev. Year) **Funeral** 1 M 2 □ F Days Hours Vrs Director 213-28-4360 March28,1920 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Md. Baltimore Director Ft. Howard 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 6 9305 Todd Ave. 21052 USA Herns 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effect.
Department of Health and Mental Hygiene.
Important: If them 27 is merked other than "natural", or then any Injury or other traument. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Aes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2√ No Specify: Specify White þ 3√2 Widowed 4 □ Divorcad Completed 15. Decedent's Education (Specify only highest grede complated) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use ratirad) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collage (1-4or 5+) 11 yrs. Self Employed U.S. Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Sumeme) Stephen G. Labuda Alexandia Golabieski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Ernestine Puffinburger 9305 Todd Ave. Ft. Howard Md. 21052 20b. Place of Disposition (Neme of cemeter, cremetory or other place)
Sacred Heart Of Jesus 9-9 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Dundalk 22. Name end Address of Facility Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, or heart failura. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final disease or condition resulting in death) Examiner Examiner the death certificate be executed and Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated avants resulting in death) Last physician at s the burial-t Box 68760 Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. o. 23b. Did tobacco use contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Nonknown Completed by 24b. Wara autopsy findings evailable prior to completion of cause of death? 24e. Was an autopsy performed? page certificate al or Attending Physician: The safter death.

If Director: After this certificate in by the funeral director, pa Division of Vital 25. Was casa referred to medical Be 26. Placa of Daath (Check only one) examinar? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 27. Magher of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending Investigation 1 □ Yes 2 □ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the bast of my knowledge, daath occurred at tha time, date and placa, and due to tha cause(s) and manner as stated.

Medicat Examinar: On the basis of axamination and/or investigation, in my opinion, death occurred at the tima, date and placa, and due to tha causa(s) and mannar stated. 29a. Cartifier (Check only one) 296. Signature and f person who complated gauss of death (Itam 23a) (Type, Print) 0

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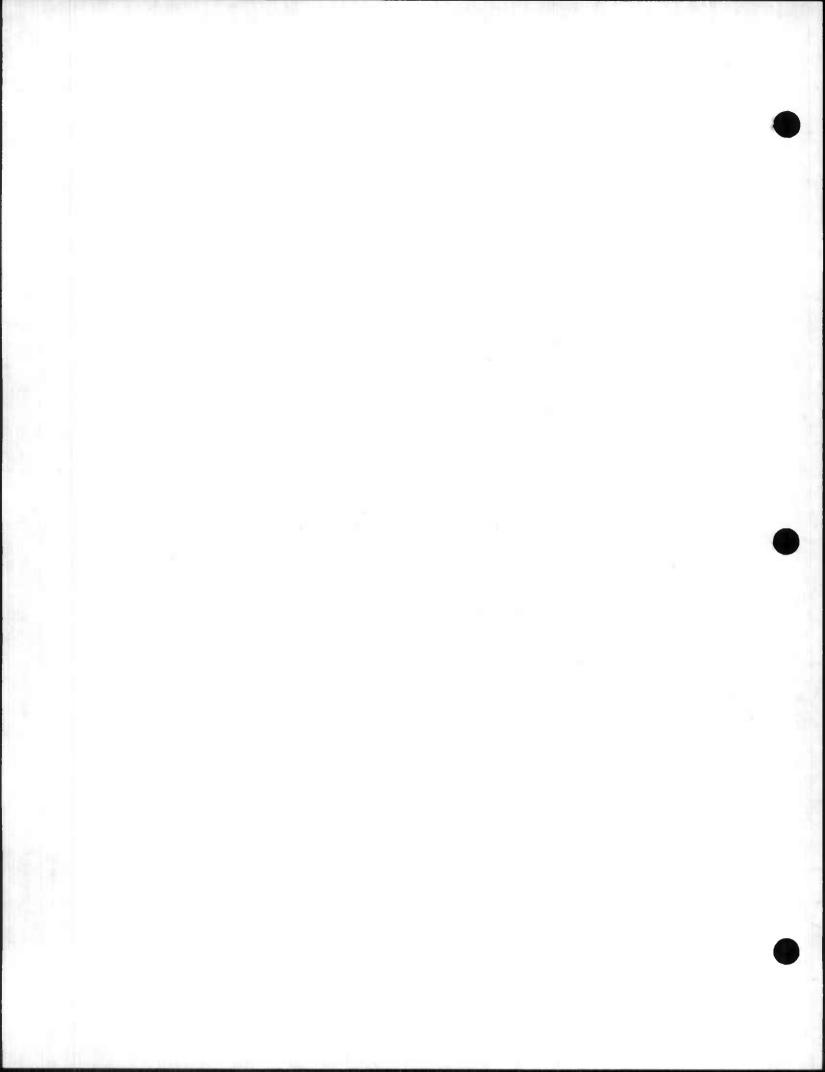
State Registrar 31. Date filed (Month, Dey, Year) 32. Registrar's Signature SEP 1 0 1997 Suka Daydson-fundale



VOID
CERTIFICATE **
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SEE
FETAL DEATH
CERTIFICATE **

97-00722



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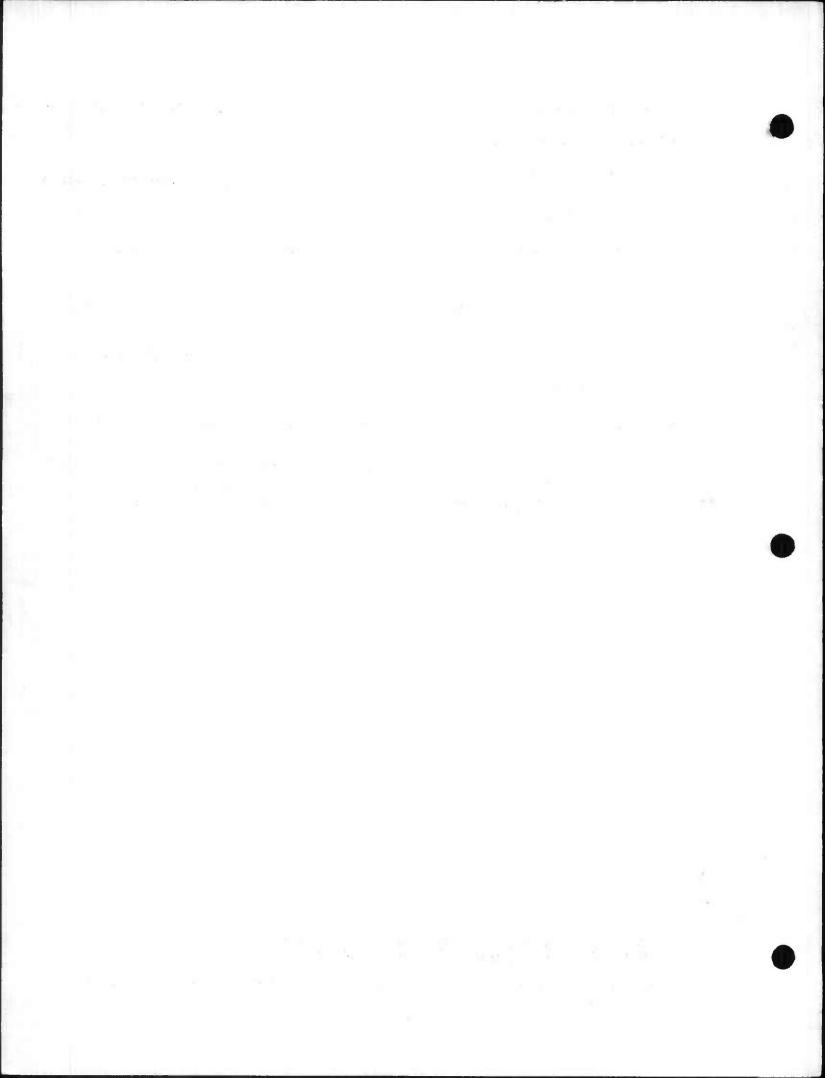
State of Maryland / Department of Health and Mental Hygiene

27421 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** SEPTEMBER 1 1997 8:30 PM STEVE LAWRENCE, JR. /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** VA MHCS FORT HOWARD DIVISION N/A BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthdev) **Funeral** 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 15 M 2□ F Months Days Hours 213-07-3354 87 Vrs Director JAN. 11,1910 PENNSYLVANIA Usual Residence of Decedent Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. fnside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD CITY BALTIMORE CITY 1 Yas 2 No Director the 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 612 SOUTH ROBINSON STREET 21224 U.S.A. Funeral 12. Wes Decedent Ever In U,S. Armed Forces?
1 ♥ Yes 2 │ No If Yes, Give Yeer or Dates: 42 ─ 45 Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 21215-0020 1□ Yes 2☑ No Specify: à Specify: WHITE 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filed within Elementery/Secondery (0-12) College (1-4or 5+) Hyglene. LABORER BETHLEHEM STEEL 8 Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If item 27 is marked othe any injury or other traumatic event ones. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be STEVEN LAWRENCE anna saxon 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH LAWRENCE/BROTHER 404 JOPLIN STREET BALTIMORE, MARYLAND 21224 Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 □ Cremetion 3 □ Removal from Stete 4 □ Donetion 5 □ Other (Specify) OAK LAWN CEMETERY SEPT.5,1997 BALTIMORE, MARYLAND 21. Signature ON-Funeral Service Lice 22. Name and Address of Fecility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVENUE BALTIMORE, MD 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory srrest, shock, or heart fellurs. List only one cause on each line. Approximete friterval Between Onset and Deeth Physician METASTATIC CARCINOMA TO LIVER /Medical Immediate Cause (Finel disease or condition resulting in death) PRIMARY SOURCE NOT KNOWN MONTHS Examiner Due to (or as a consequence of): Examine the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury and Due to (or es e consequence of) attending physician a for use as the burial-O. Box 68760 Physician/Medical eted events Due to (or as e consequence of) resulting in deeth) Lest Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 4 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown COPD, PULMONARY FIBROSIS, ALZHEIMER'S DEMENTIA þ Records 24b. Were eutopsy findings sysilable prior to completion of cause of death? Completed 24e. Wes an autopsy ASBESTOS EXPOSURE 1 Yes 2 No 1 XYes 2 □ No certificata Division of Vital Physician: 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Ves 2X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 27. Manner of Deeth After t Certification: 28d. Describe how Injury occurred or Attending 1 Neturel 5 Pending Investigation death. 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) after 4 Homicide A 24 hour. the Funeral Dire Hospital 29a. Certifler 1 Certifying Phyeician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner as steled.

2 Medical Examiner: On the best of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the ceuse(s) end manner steled. edical (Check only within 2 To the 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 2, 1997 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) AURORA C TAN, M.D. 9600 NORTH POINT RD FORT HOWARD, MD 21052 31. Date filed (Month, Dey, Year) SEP 1 0 1997 32. Registrar's Signeture State ha Davidson-Randell 1 0 1997

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Date of Death 3. Time of Deeth **Physician** O Month MAURIKOS JACQUELINE 06 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner BON SECOUR HOSPITAL BALTIMORE N/A 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 09/13/1942 Birthplace (State or Foreign Country)
 MD **Funeral** 1 □ M 2 🗓 F Months Days Hours Min 54 Yrs. 215-40-9179 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Depertment of Heelth end Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examinal must be notified at 10a. Slate 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3303 GWYNNS FALLS PARKWAY Funeral 21216 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Orlgin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: WHITE þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondery (0-12) Cotlege (1-4or 5+) 8 NURSES AIDE NURSING HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be JOHN SHEPARD MAUD CLEMONS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) MARGARET HOWARD/ SISTER 6225 YORK ROAD APT. N-417 BALTIMORE, MD 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State CHESAPEAKE CREMATORY 9/9/97 BELTSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune at Service Licenses 22. Name and Address of Facility
STERLING ASHTON FUNERAL HOME, INC EDMONDSON AVE. CATONSVILLE, MD 21228 the disease, or mous shock, or heart feilure. List only ons that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death **Physician** /Medicai Immediate Cause (Final neunang disease or condition resulting in death) Examiner Due to (or es a consequence of) Examiner arcenema requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last pue Due to (or as a consequence of): Records, P.O. Box 68760, ettending physician Physician/Medical Due to (or as a consequence of): Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prtor to completion of cause of death? Completed 24a. Was en eutopsy 2000 1 ☐ Yes 20 No 1 Yes Vital 25. Was case referred to medical exeminer? Be 26. Piece of Death (Check only one) Hospital tnpatient 2 ER/Outpatient 3 DOA 2 Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes € No Division of 量 To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After this funeral 28e. Date of Injury (Month, Day Year) Certification: 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Naturai 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Sulcide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify) in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) Medicai 29a. Certifier (Check only one)

29c. License number

BALTIMORE, MARYLAND

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 2717 HAMMONDS FERRY ROAD

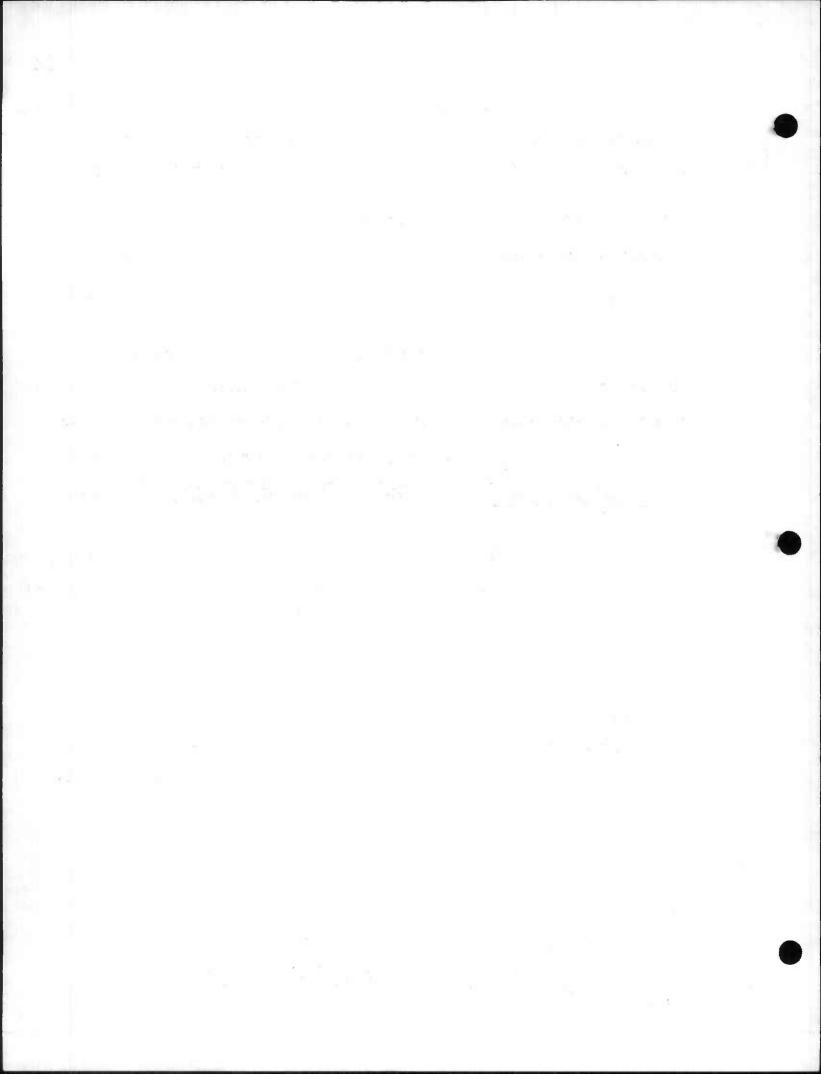
La Lawrence Standing

29d. Date signed (Month, Day, Year)

21227

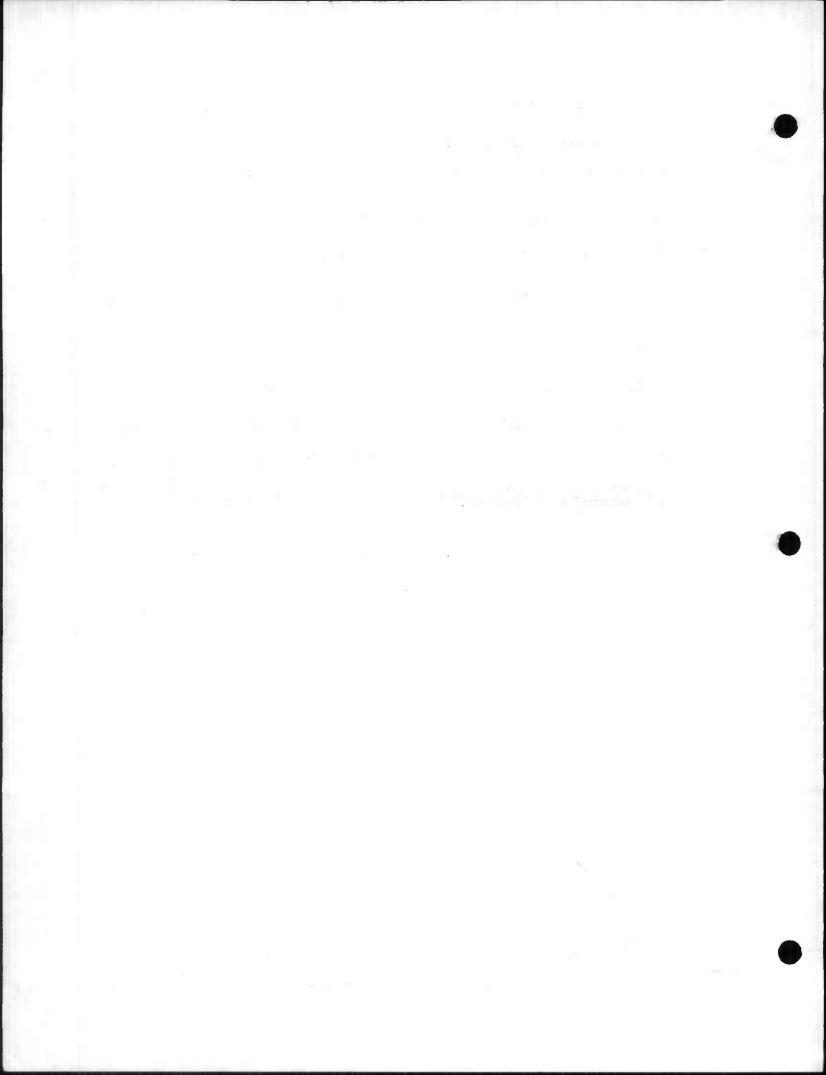
Registrar

29b. Signature end title of certifier



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| _ | | | | | Cer | tificate of | | мена пу | Reg. No. 9 | 1 2 | 7423 |
|---------------------|--|---------------------|---|---|--|--|--|---|---|----------------------------------|---|
| ı | Physic | | Decedent's Name (First, Middle, La JOHN D. | McDOWELL | SR. | | | 2. Date of De Month SEPT. | | | Time of Deeth 11:47 am |
| N | /Medi Examii | | 4a. Facility Name (If not institution, given | | | | 4b. City, Town, or | | | _ | 11.47 all |
| - | Funeral Director | | | Sex 7. Aga (| MEDICAL (In yrs. last birthday) Yrs. | if Undar 1 Yaa Months Day | | 8. Date of Bir (Month, Da | N/ ay, Year) 9 23,1918 | Birthplace Country) | (State or Foreign |
| - | | | Usuel Residence of Decedent | | 79 | | | July . | 23,1910 | | SOURI |
| | Manyla f show | ō | Md. BALTIM | | ا 10c. City, Town or Loc | rimore | | | | | nside City Limits |
| | r 28a | rect | 10e. Street and Number | JKB | DAU. | 10f. Zip Code | | | 10g. Citizen of Wha | | Α |
| | 23a o | ral D | 6910 GOUGH S | STREET | | 212 | 224 | | U.S.A. | | |
| 020 | 72 hours after death with the Maryland natural, or items 23s or 28s-f show Josi Examinor must be notified at | by Funeral Director | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedeni Ev Armed Forces? 1√√yes 2 □ No If Yes, Give Year or Dates: ↓ |) if | Vas Decedani of Yes, specify Cu ☐ Yes 2 【XNo | Hispanic Origin? (Suban, Mexican, Puar Specify: | Specify Yes or No to Rican, etc.) | 14. Raca - Black, Specify: | American In White, etc. | |
| Maryland 21215-0020 | filed within 72 hours Hygiena. other than "natural", ent, the Medical Ess | Completed | 15. Decedent's E (Specify only highest gr. Elementary/Secondery (0-12) 1 2 | ducation | 18a. Deced (Give I | ent's Usuel Occi kind of work don OO NOT use retii | a during most of wa | | 16b. Kind of Busin | TI CO | |
| pu | | Be C | 17. Father's Name (First, Middle, Last |) | | | 18. Mother's Na | ma (First, Middle | , Maiden Sumeme) | | |
| yla | | To | CLYDE McDOV | | | | ROSE | / | | | |
| Ma | d the | | JOHN McDOWELL, J | | | | | | er, City or Town, Ste | | |
| Baltimore, | Pagas 1 and nant of Haalth int: If Item 27 ary or other tr | | 20a. Method of Disposition Durial 2 Cremation 3 Donation 5 Other (Specia | | 20b. Place of Dispos | sition (Neme of netory or other pi | aca) | Date | FESVILLE 20c. Location - Cit Baltimor | ty or Town, S | Stete |
| Balt | permit. Page Department of Important: If any Injury or once. | | 21. Signature of Funeral Service Licer | nsee | MA | Name and Add | | | 6224 Ea | | |
| | Physician /Medical Examiner | Examiner | 23a. Part1. Enter tha disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) | a. CAR | | ARRES | T | | | Ons | oroximate rval Between set and Death |
| Box 68760, | death cartificete be executed a attending physician end od for usa es the buriel-transit | edical | Sequentially list conditions, if any, leeding to immediate cause. Entler Underlying Cause (Disease or Injury that initieled events resulting in death) Last | C | ue to (or as a consequ | | | 1 | DISEASE |) | |
| P.O. | 0 0 0 | Physician/M | Part It. Other significant conditions of | contributing to death but i | not resulting in the un | derlying cause o | given in Part I. | | tobacco uae contri Yes 2 No 3 | | cause of death? |
| Records, | He is the vires that the | Completed by | | | | | | 24a. Was perfo | ormed? | available complet of death | utopsy findings le prior to tion of causa 17 |
| 喜 | | Bec | 25. Was case referred to medical examiner? | | | | 26. Piaca of De | ath (Check only | | 10.100 | 2010 |
| of V | Physic this ce | 2 | 1 Yes 21 No | Hospitel: | - V | 3LI DOA | | | denca 8 Othar | Specify) | |
| lon | Attending I or death. ector: After by the funer | ation | 1 Statural 5 Pending | 28a. Date of Injury (Month, Day Y | (ear) 28b. Time of Injury | 28c. tnj W M 1[| ury at ork? ☐ Yes 2 ☐ No | 28d. Describe | how Injury occurred | | |
| Division of Vital | 5 4 4 5 | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined | | - At home, farm, stre (Specify) | eet, factory, office | 9 | 28f. Location (City or To | Street and Number own, State) | or Rural Rou | ite Number, |
| | To the Hospital within 24 hours e To the Funeral I complately filled | edicai | 29a. Certifier 1 ✓ Certifying Ph (Check only one) 2 ☐ Medicat Exar | nystcian: To the best of miner: On the basis of example and manner stete | camination and/or Inv | occurred et the estigation, in my | time, dete end place opinion, death occu | a, and due to the urred at the tima, | cause(s) end menne date and place, and | er es stated. I due to the | cause(s) |
| | To the within To the | Me | 29b. Signatura end title of cartifier | | | 29c. Licer | nse number | | 29d. Date signed (A | Month, Day, | Year) |
| | | | Papara Cu | | | DI | 5834 | , | 9.9. | 97 | |
| | Sta | ite | 30. Name end address of person who 31. Date filled (Month, Day, Yeer) | completed cause of deal | ND 34 | Print) | ANKSTA | RECT | BA CTO | MD | 21224 |
| | Registr | | SEP 1 0 1997 | que verdon | 1- Mandelle | | | | | | |



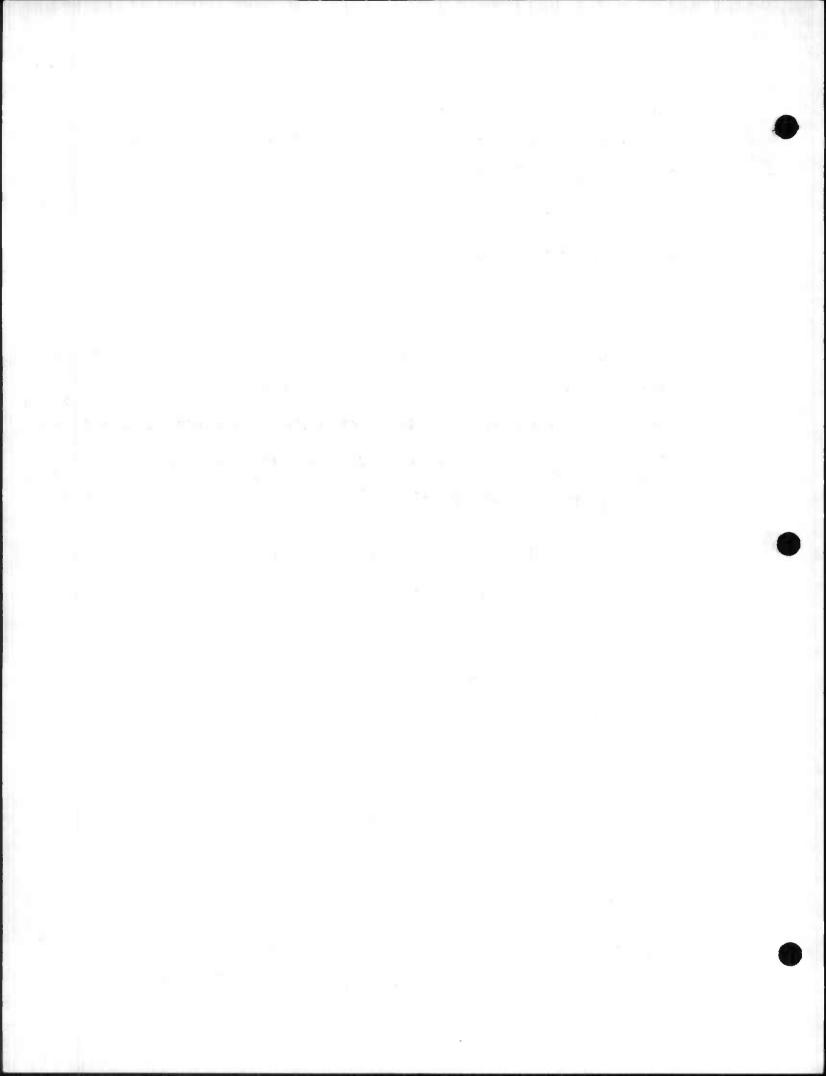
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State of Maryland / Department of Health and Mental Hygiene 0.7

| | ga L | | Decedent's Nama (First, Middla, Last, |) | | Ce | rtificate of | Dealli | 2. Data of Dea | | | 3. Time of Death |
|------------|--|------------------|---|--|-----------------------------------|-----------------------------|--|--|--|----------------------------------|------------------------------|--|
| | Physic /Medi | | Marguerite | | Mu | rray | | | Sept. | O5 | 97 | 5:27pm |
| | Exami | | 4e. Facility Nama (If not institution, giva | street and numb | oer) | | | 4b. City, Town, | or Location of Death | 4c. Coun | ty of Death | |
| | عاند | ,,, | Harbor Hospita | l Cent | er | | | Baltin | | | NA | |
| | Funeral Director | | 247-32-4641 | 7. M 2/2 F | Age (In yrs. la | st birthday) Yrs. | If Undar 1 Yea Months Days | | rs. 8. Data of Birtl in. (Month, De) 08-06 | h v, Year) -33 | 9. Birthp Coun | lace (Stata or Foraig SC |
| | and * | | Usual Rasidence of Decedant 10e, Stata 10b, County | | 10c. City | Town or Lo | cation | | | | 1 | 0d. Insida City Limits |
| | /enyl | ō | Md. NA | | - | ltimo | | | | | | XXYas 2 No |
| | the h | ect | 10e. Street and Number | | | | 10f. Zip Coda | | | 10g. Citizan of | What Coun | |
| | 3a or | 0 | 4505 White Oak | Avenu | 0 | | 2121 | 5 | | | JSA | y. |
| | death | Funeral Director | | 12. Was Deceda Armed Force | | . 13. | | | (Specify Yas or No- arto Rican, etc.) | | ice - Americ | |
| 21215-0020 | be filed within 72 hours effer death with the Meryland tel Hygiene. d other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be norified at | þ | 1 ☐ Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | Armed Force 1 ☐ Yas 2 If Yas, Giva Yaar or Date | XNo | | If Yes, specify Cul | | arto Rican, etc.) | Spec | eck, Whita, ify: Bla | |
| 5-0 | 72 ho | ted | 15. Decedant's Edu (Specify only highest grade | cation | | 16a. Dece | dant's Usual Occu kind of work done DO NOT usa ratin | pation | unding | 16b. Kind of | | The same of the sa |
| 21 | ithin ithin | Completed | Elamantary/Secondary (0-12) | Collega (1-4 | or 5+) | lifa. | DO NOT usa ratin | ed) | TOTKING | | | |
| | S should be filed within end Mentel Hygisne. Is marked other than aumatic event, the M | Co | 10th Grade | NA | | Do | mestic | T 40 14 11 11 1 | | | | rades |
| and | t be fi | Be | 17. Fathar's Nama (First, Middla, Last) John Jordan | | | | | Mary | lema (First, Middla, | | | |
| Maryland | should and Men marke | To | 19a. Informent's Name/Relationship (Ty | | | 10b Mallin | a Addrage (Street | _ | | | yrd | Code) 21218 |
| Ma | 0 0 0 0 | | | tthews | | | | | reet Ba | | | |
| re, | s 1 and 2 should be filed if Heelth end Mentel Hyg Item 27 is marked othe other traumatic event, | | 20a. Mathod of Disposition | CCHEWS | | | sition (Nama of natory or other ple | | Date | 20c. Location | | |
| OE | 6 = 5 | | 1 Sp Buriel 2 □ Cramation 3 □R 4 □ Donation 5 □ Othar (Spacify) | amoval from Sta | 9129 | | | | -11-97 | н;11. | shore | , Md. |
| Baltimore, | - 돌림을 | | 21. Signature of Funeral Service Lights | 10 / | Dui | | 2. Neme end Addr | | | | | nd 21202 |
| ä | Depermination of the policy of | | Monney | MA | 1100 | | | | 1101 E | | 640 | |
| | | | 23a. Part1. Entar the disease or complishock, or heart feilure. List only on | delicons that cau | sed the death. | Do not ant | ar tha moda of dy | ing, such as card | iac or raspiratory ar | rest. | | Approximata |
| J | Physician | | shock, or haart feilure. List only on | a cause on eac | h lina. | | | | | | ì | Approximata Intervel Between Onsat and Death |
| 1 | /Medical | | Immediata Cause (Final diseasa or condition | Mus | mad | 10 | anto | arctio | | | + | ermine! |
| п | Examiner | | resulting in death) | 1.190 | Dua to (or | as a consec | quence of): | 110110 | | | | (1111111) |
| | D # | Ine | | Hu | pert | Pn | sion | | | | | Ulgis |
| | eath certificete be executed ettending physician and for use es the burial-transit | Examiner | Sequantially list conditions, | | Dua to (or | as a consec | uance of): | | | | |) |
| 60, | be ex cian burial | a E | Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaase or Injury that initiated evants | Ath | e105 | cler | 0515 | | | | | Jeans |
| 68760, | physic the | edicai | that initiated evants resulting in death) Last | | Dua to (or a | as a conseq | uence of): | | | | |) |
| | ding | 100 | | | | | | | | | İ | |
| Вох | etten for u | Physiclan/N | | | | | | | | | ! | |
| P.0. | that the di ed by the deteched | ysi | Part II. Other significant conditions con | tributing to daat | h but not rasult | ting In the u | ndarlying causa g | ivan in Part I. | | | | the cause of death |
| | es that gned b | by Pi | Diabete | 8 /1 | 1e111 | tous | | | _ '''' | Yes 2□ No | 3L Prot | bably 4 Unknow |
| Records, | | | | | | | | | 24e. Wes | an autopsy | 24b. We | ere eutopsy findings |
| 00 | > A 6 | Completed | | | | | | | репо | rmed? | CO | aitable prior to mpletion of cause death? |
| E, | Partie Partie | E | | | | | | | 1 D Y | as 2 No | 10 | Yas 20 No |
| Ital | DA | Bec | 25. Was casa rafarrad to medical | | | - | | 26. Pleca of D | aeth (Check only o | na) | | |
| 6 | 母號 | To | axaminer? 1 ☐ Yas 2 No | ospital: | atiant 2 E | R/Outpatier | AOD DOA | ther: | Home 5 ☐ Resid | | ther (Specifi | () |
| 0, | Ilng Pr Afte funera | | 27. Manner of Death 1 Natural 5 ☐ Panding | 28a. Data of I (Month, | njury Dey Year) 2 | 8b. Tima of | 28c. Inju | ury at | 28d. Dascribe h | ow injury occu | rred | |
| Sio | Attending r death. sctor: Afte by the func | cati | 2 ☐ Accidant invastigation | | | | M 1 | Yes 2 □ No | | | | |
| Division | | Certification: | 3 ☐ Suicida 6 ☐ Could not be datarminad | 28e. Place of building, | injury - At hom atc. (Specify) | na, farm, str | aet, factory, office |) | 28f. Location (S City or Tow | Straet and Num m, Stata) | ber or Rura | I Routa Number, |
| | urs e vral D | | One Continue Park | | | | | | | | | |
| | To the Mospital or within 24 hours effe To the Funeral Dir completely filled in | edical | 29a. Cartifiar Certifying Phys | ician: To the be er: On the basis and manner | s of exeminetic | edga, daath on end/or in | occurred at tha t vastigation, in my | ima, data and pla opinion, daath oc | ce, and due to the c curred at tha tima, o | causa(s) end n data and place | nannar as st , and due to | eted. tha cause(s) |
| | o the o the ompli | Me | 29b. Signeture end titla of certifiar | | | | 29c. Lican | sa number | | 29d. Data sign | ed (Month, | Day, Year) |
| | F S F Ö | | Amatun A | 1. Mas | eem 1 | M.D | DI | 5503 | | Sept | 8 | 1997 |
| | 5 | | 30. Nema and eddress of person who co | | | | | | | | 2 | 0 |
| | .) | | 1 :- 1 :- 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | ILAE | Tom P | 211 | Milohi | n STr | of the | ITIMA | ve IVI | 1) /1/1/- |

State Registrar

31. Data filed (Month, Dey, Yaar)



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State of Maryland / Department of Health and Mental Hygiene 97

27425

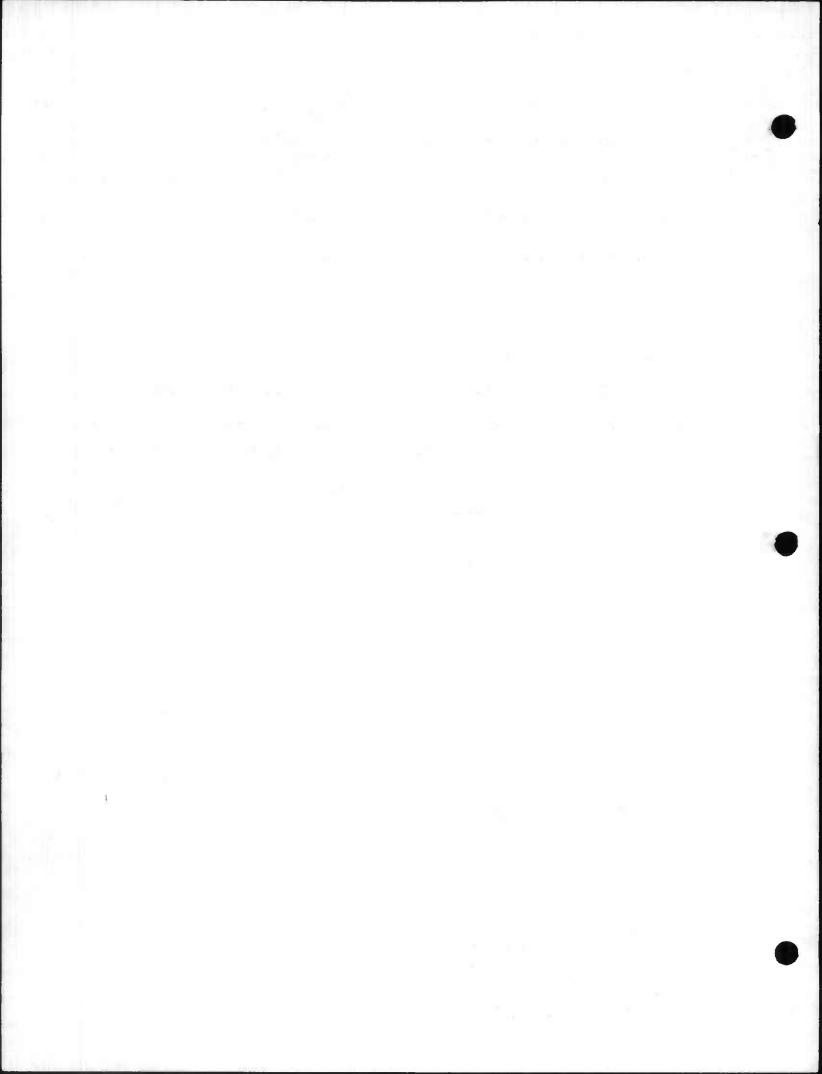
| _ | | | | | | | C | ertifica | e of | Death | | | Reg. No. | | 444 | |
|---------------------|--|----------------|---|---------------------------|----------------------------|-----------------------------|------------------|---|-------------|-----------------------------|------------|-----------------|------------------|--------------|--|----|
| П | Dharata | | 1. Decedent's Name | | | | | | | | | 2. Date of De | eath | Vaca | 3. Time of Death | |
| | Physici /Medi | | 7 | Macy Mat | thews | | | | | | | Month Sept | . 8, 19 | 97 | 9:15 pm | |
| N | Exami | | 4a. Facility Neme (II | | | | | | | | | cation of Deal | | y of Desth | | |
| 1 | | | Dulaney | Towson I | Health (| Care C | enter | | | Tow | son | | Ba | ltimo | re | |
| Г | Funeral | Г | 5. Sociei Security N | | Sex | 7. Age (In | yrs. last birthd | | r 1 Year | if Under | | 8. Date of Bi | rth Namel | 9. Birthp | lace (State or Foreign | n |
| ø | Director | | 231-14-66 | 551 | 1□ M 21 F | 7 | 3 Yrs | Months | Days | Hours | Min. | Sept. | 14. 192 | 3 Vir | ginia | |
| | P. | | Usual Residence of | | | | | | | | | | | | | |
| | anylar show | | 10a. State | 10b. County | momo | 10c. | . City, Town o | | 2011 | | | | | 1 | 0d. Inside City Limits | |
| | o Me | ct | Md. | Dalt | rmore | | Kel | sterst | own | | | | | | 1 Yes 2 No | |
| | or 21 | Director | 10e. Street and Nun | | | | | 10f. Zij | Coda | | | | 10g. Cltizan of | What Cour | ntry? | |
| | death with the Maryland ime 23a or 28a-f show Ir must be notified at | | 321 1 | Holly Hi | TT Kd. | | | | 21 | 136 | | | U. | S.A. | | |
| | dea - | Funeral | 11. Maritel Status | | 12. Was Dec | | n U,S. 1 | 3. Wes Dece | dent of H | Ilspanic Orl an, Mexicar | gin? (Spe | cify Yes or No | - 14. Ra | ce - Americ | | |
| 0 | or h | | | ed 2 Married | | 2 🕅 No | | 1 ☐ Yes | | Specify: | , | | | | | |
| 000 | ours irel'. | d by | 3 N Widowed | 4 Divorced | Yeer or E | Dates: | | 1 1 1 1 1 1 1 1 1 | 230110 | орвану. | | | Specif | y: Whi | .te | |
| 5 | 72 h | Completed | (Speci | 15. Decedant's E | ducation ade completed) |) | 16e. De | cedent's Usu ive kind of wo e. DO NOT u | al Occup | ation during mos | t of worki | na | 16b. Kind of B | usiness/in | dustry | |
| Maryland 21215-0020 | ithin Ne. | dr | Elamentary/Secon | ndary (0-12) | College (| 1-4or 5+) | `lif | House | | d) | | | Uo# | emake | 20 | |
| 7 | od v ygje yer ti | S | 8 | | | | | nouse | MITE | | | | | | 1 | |
| und | tal H d out | Be | 17. Fether's Name (| | | | | | | 18. Mothe | | | , Maiden Sumar | ne) | | |
| Yes | ould Men arke | 2 | | mas Musi | | | | | | | OT | ga Gord | iou | | | |
| Jar | 2 sh and is m | | 19a. Informant's Na | me/Relationship | (Type, Print) | | | | | | | | er, City or Town | | | 1 |
| | and ealth m 27 | | Bobbie | | | | | | | T Ka. | , Ke | isters | town, Md | · STI | .50 | |
| altimore, | r of H | | 20a. Method of Disp | osition Cremation 3 [| Removal from | State | | rematory or | othar place | | | Date | 20c. Location | | N. P | |
| E | men ant: ury | | | 5 Othar (Speci | | | Druid . | Ridge | Cem. | Sept | . 11 | , 1997 | Pikesvi | lle, | Md. | |
| a | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other treumatic event, the Mudical Examinet must be notified at once. | | 21. Signeture of Fur | neral Service Lice | nsee | 11 | | 22. Name e | | | | | | | | |
| m | 20539 | | N H | 7. Sale | hard | 1 | | Eckha 11605 | rdt . | Funer | al C | napel (| Wines N | HIIs. | Md. 2111 | 7 |
| | | | 23a. Part1. Enter in shock, or hear | a disease, or com | plications that | caused the d | leath. Do not | enter the mod | da of dyln | ng, such as | cerdiac o | r respiratory e | rrest, | Ĭ | Approximate Intervel Between | i |
| | Physician | | | | | | Λ | | | | | | | | Onset end Death | |
| | /Medical | | Immediate Ceuse (I diseese or condition | | | | Pno. | 11.10- | 11/ | | | | | | | |
| | Examiner | | resulting in death) | | θ | Dua | o (or as a con | UM J | ruc | ~ | | | | 1 | | - |
| _ | n # | Examiner | | | | not | 64 | 4: | . 1 | -/ 20 | 11 - | ~ ~ ~ | nome | | | |
| | certificete be executed ding physician and ise as the burial-transit | a a | Sequentially list con if eny, leading to im- | ditions, | b// | Dua t | o (or as a con | sequance of) | NO | rev | 106 | asu | Y CAYL | 7. | | 10 |
| ó | e exe | | ceusa. Entar Under | rivina 🛲 | | / | TANGA | r do V | | 120 | VA | 6: | 1000 | | | |
| 68760, | ete b hysic the b | lca | Causa (Disaase or i that Initiated events resulting in deeth) L | | C | Due to | o (or as a cons | sequence of): | V | yes | 1/ | land. | MITE | 1 | | - |
| | certific nding p | /Medical | , , , | | | | V | | | | | | | | | |
| Box | 2 5 3 | | | | d | | | | | | | | | | | - |
| | 0 0 0 | Physician | Part II. Other signific | cant conditions | contributing to d | eath but not | resulting In the | e underlying | euse giv | an In Pert I | | 23b. Dld | tobecco use co | ontribute to | the cause of deeth? | ? |
| P.O. | that the ed by th detechs | F | | Al | 11-00 | , | 4.1 | 12. | 1. | 24. | , | 10 | Yes 2 No | 3 Prot | pably 4 Unknow | n |
| Ś | es tha igned be del | þ | | (V) 30 | domi, | nal | NO | 8416 1 | VIIC | No sh | Sm | | | | | |
| Š | requires been sign should be | | | | | | | | | | | | an autopsy | | ere sutopsy findings allable prior to | |
| Ö | > 10 00 | ple | _ | | | | | | | | | | | CO | mpletion of ceuse death? | |
| ď | 0 - 5 | Completed | | | | | | | | | | 10 | Yes 2 No | 10 | Yes 20 No | |
| Vital Record | iclan: The certificate rector, pag | 0 | 25. Was cese refarr | ed to madicel | | | | | | 26 Placa | of Death | (Check only | | | X | - |
| | | lo B | examiner? | | Hospital: | Inpatient 2 | 2 ☐ ER/Outpa | tient 3 D | OA Oth | | | | dence 6 □Oth | ner (Specifi | y) | |
| 0 | | n: T | 27. Mannar of Death | | 28a. Date | of tnjury | 28b. Time | | 28c. Injun | | - T | | how injury occur | | , | - |
| Division of | or Attending i ofter death. Director: After in by the funer | atio | 1 Naturai 2 Accident | 5 Pending investigation | | ith, Day Year | r) Injur | м | | Kr Yes 2 🗆 I | No | | | | | |
| VIS | or Attendi efter death. Director: A I in by the fo | ific | 3 ☐ Suicide 4 ☐ Homicide | 8 Could not be determined | 28a. Place | of Injury - A | t home, farm, | street, factor | y, office | | 2 | | Street and Numi | ber or Rura | l Route Number, | |
| | s effer Il Director | Certification: | 4 🗆 Homicide | | build | ing, etc. (Spe | өспу) | | | | | City or To | wn, State) | | | |
| | To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral | _ | 29a. Cartifiar | Certifying Pr | ysicien: To the | best of my l | knowledge, de | ath occurred | at tha tin | ne, date an | d place, a | ind due to tha | causa(s) and m | anner as st | ated. | |
| | in 24 in 24 in Fr. | edical | (Check only one) | 2 ☐ Medical Exam | giner: On the b | asis of exam nar steted. | unation and/or | Investigation | , in my o | pinlon, deal | h occurre | ed at the time, | date and piece, | end due to | the ceuse(s) | |
| | To the within 2 To the comple | × | 29b. Signature and t | titla of certifier | 11 1 | N. | | 29 | c. License | e number | | | 29d. Date signe | d (Month, | Day, Year) | |
| | 0/ | | | | 1100 | '_ | | 7 | Suit | 701. | | | Glin | 10 | 7 | |
| | 8 | | 30. Name and addre | ss of person who | completed ceus | se of death (| Item 23a) (Tvr | e, Print) | 774 | 1-14 | | | | 17 | 1151111 | n |
| | W. | | MOHAN | NMEN | AL | MIF |) Maa | GE | -13 | 14 | AN | FORM | RD | BL | 15/10/10 | 14 |
| | Sta | te | 31. Date filed (Month | h, Day, Year) | 320 | logietror's Si | onatura | 13 | 10 | -111 | 1/1 | | 1 | / | 0,009 | , |
| | Registr | - | SEP | 1 0 1997 | Jul | te David | sor-Rang | مكالم | | | | | | | | |
| _ | | | | | 7.5 | | - | - | | | | | | | | _ |

ALLEN FILLER 17.55 A. 17.

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

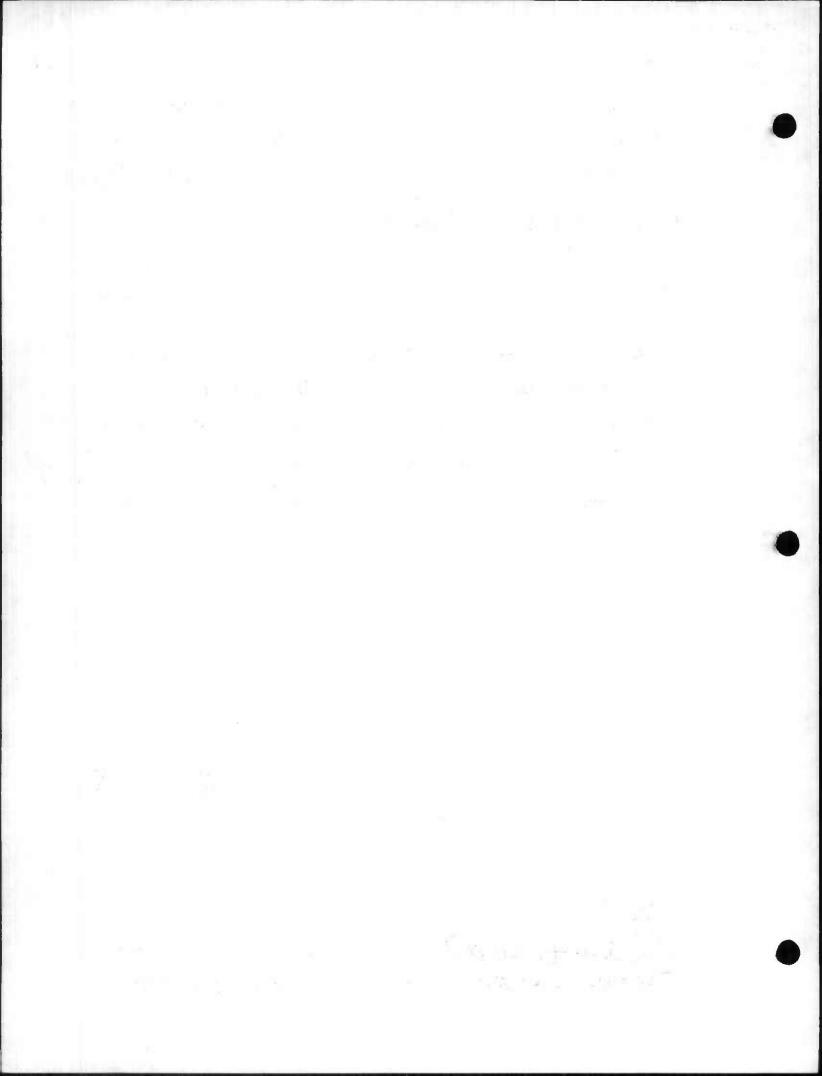
State of Maryland / Department of Health and Mental Hygiene 0.7

| _ | | | | | | rtificate d | of Death | | g. No. | 1 21 | 426 |
|------------|---|---------------------|--|---|--------------------------------|---|--|---|-----------------------------------|---|---|
| П | Physic | ian | 1. Decedent's Name (First, Middle, Last) | | | | | 2. Dete of Deet Month | Dey | Voor | . Tima of Death |
| 4 | /Medi | | 4e. Facility Neme (If not Institution, give s | | | | 4h City Town or | Location of Deeth | 4c. County | / / / | 7:45 AM |
| 4 | Examiı | ner | SINAI HOSPITAL | Control of the control of | FROME | | BALTIM | | 4c. County | N/A | |
| | Funeral Director | | 5. Social Security Number 6. Sex | | (In yrs. last birthday, | if Undar 1 Ya Monihs Da | ar if Under 24 Hrs | 8. Daie of Birth | Year) 1927 | | e (Steta or Foreign and |
| | yland M M | | 10a. State 10b. County | 1 | IOc. City, Town or L | ocation | | | | 10d. | inside City Limits |
| | the Marylar 28a-f show notified at | ctor | Maryland Anne | Arundel | | Pasade | ena | | | | 1 ☐ Yas 2½ No |
| | or 28 | Dire | 10e. Sireet and Number | | | 10f. Zip Cod | | 10 | g. Citizen of V | | |
| | s 23a | ig. | 320 S. Carolina Av | | | | 21122 | | | U.S.A | |
| 020 | n 72 hours efter deeth with the Maryla "natural", or flems 23a or 284-1 show adical Examines must be notified at | by Funeral Director | 11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced | Wes Decedeni Ev Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yaer or Delas: | ar in U,S. 13. | if Yes, specify C | of Hispanic Origin? (Suben, Mexican, Puer No Specify: | to Rican, etc.) | Blec | a - American k, White, etc. : White | indien, |
| 21215-0020 | permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Maryland Depertment of Heelth and Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show ship follury or other traumetic event, the Medical Examiner must be notified at ance. | Completed | 15. Decadent's Educ (Specify only highast grade Elementery/Secondery (0-12) | cation completed) College (1-4or 5+) | | dent's Usuei Oc kind of work do DO NOT use re Mist | cupetion ne during most of wo lired) | orking | 16b. Kind of Bu | | try |
| d 2 | filed with Hygiene other than | | 17. Fathar's Name (First, Middle, Last) | т Z | Cile | IIIISC | 18. Mother's Na | me (First, Middle, N | Wiley Maiden Surnem | | |
| Maryland | should be end Mentel is marked o | To Be | William A. | MacKenzie | 9 | | Loui | se F. Rei | nisch | | |
| lary | 2 should end Men is marke | | 19a. Informeni's Neme/Relationship (Typ | | | ing Address (Str | eet and Number or R | ural Route Number, | City or Town, | State, Zip Co | de) |
| | 1 end Heelth em 27 | | Larry Mackenzie | Brother | | | olia Ave. | | | | |
| Baltimore, | permit. Pages 1 and 2 should be filed withir Department of Heelth and Mentel Hygiene. Important: If item 27 is marked other than mark in July or other traumatic event, the Mance. | | 20e. Method of Disposition 1 □ Buriel 2 ☑ Cremetion 3 □ Ro 4 □ Donetion 5 □ Other (Specify) | emovel from State | 20b. Pleca of Disp Metro Cr | elliatory | Sept.5,1 | .997 E | Baltimo | | |
| Bal | permit. Pag Department Important: It any Injury o | | 21. Signeture of Funeral Service Lican | Kome | /// M | | drass of Facility Polyniak F ntain Road | | | and 21 | 122 |
| | Physician /Medical Examiner | | 23a. Pert1. Enter the diseese, or complic shock, or heert feilure. List only on Immediate Cause (Final disease or condition resulting in deeth) | Sep | SUS ue to (or es e conse | | dylng, such es cardia | c or respiretory arre | st, | Int | proximete ervel Between aset end Death |
| | and transit | Examiner | Sequentially list conditions, | Du | ue to (or es e conse | quenca of): | | | | | |
| x 68760, | certificate be executed ding physician and se as the buriel-transit | Physician/Medical E | Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated evanis resulting in deeth) Lest | | e to (or es e conse | quence of): | | | | | |
| Box | leath cert ettendin d for use | iciar | Dont ii Other einnitiennt eenditiene een | inite internal and another than | | | Shirts by Boat | DOD DIAME | | | |
| , P.O. | requires thet the death cert seen signed by the ettendin hould be detached for use | by Phys | Part ii. Other significant conditions continued to the few | ributing to death but i | not resulting in the t | underrying cause | given in Pert I. | 23b. Did to | _/ | | e cause of death? |
| Records, | requir | Completed b | o besity | | | | | 24a. Wes er perform | | evellal | eutopsy findings ble prior to ation of cause th? |
| | ysician: The law r iis certificate hes b i director, page 2 st | Соп | | | | | | 1 □ Ye | s 2 No | 1 🗆 Y | es 20 No |
| of Vital | Physician: this certific ral director, | Be | 25. Wes case referred to medical examiner? | ospital: | | | | eth (Check only one | 9) | | |
| o | ± 5 | . To | 1 Yes 2 No | 1 Inpatient 28e. Date of injury | 2 ER/Outpetie | IN SLI DOX | Other: 4□ Nursing I | Home 5 ☐ Reside | | | |
| Division | Attending Ph death. ctor: After th | Certification: | 1 Neturei 5 □ Pending 2 □ Accident investigetion 3 □ Suicida 6 □ Could noi ba | (Month, Dey Y | (ear) injury | M 1 | Vork? ☐ Yes 2☐No | 28f. Location (Str | | | nute Number |
| ò | O THE | | 4 Homicide determined | building, etc. (| (Specify) | | | City or Town | , Stete) | | |
| | To the Hospital Within 24 nour To the Figure completing | Medical | 29a. Certifier (Check only one) Certifying Physical Examin | cian: To the best of r er: On the basis of an end menner stete | caminetion and/or in | n occurred et the vestigetion, in m | o time, dete end pleca y opinion, deeth occi | a, end due to lhe ce urred at the time, de | use(s) end me ete end pleca, a | nner as stete and due to the | d. e causa(s) |
| | To the I within 2 To the comple | Me | 29b. Signeture end little of cartifier | wulge | eren | | ense number | 29 | 9. 5 | (Month, Day | , Year) |
| | 4 | | 30. Name and address of person who con | mpleted cause of deer | th (Item 23e) (Type | Print) W40- | 2 Street | BALTIM | 100 60 | 02/1 | _1/ |
| | Sta | ite | 31. Dete filed (Month, Dey, Year) | ka Jandan | Signature | | 5 | | . 4 | , , | |



32. Redistrar's Signefure

State Registrar



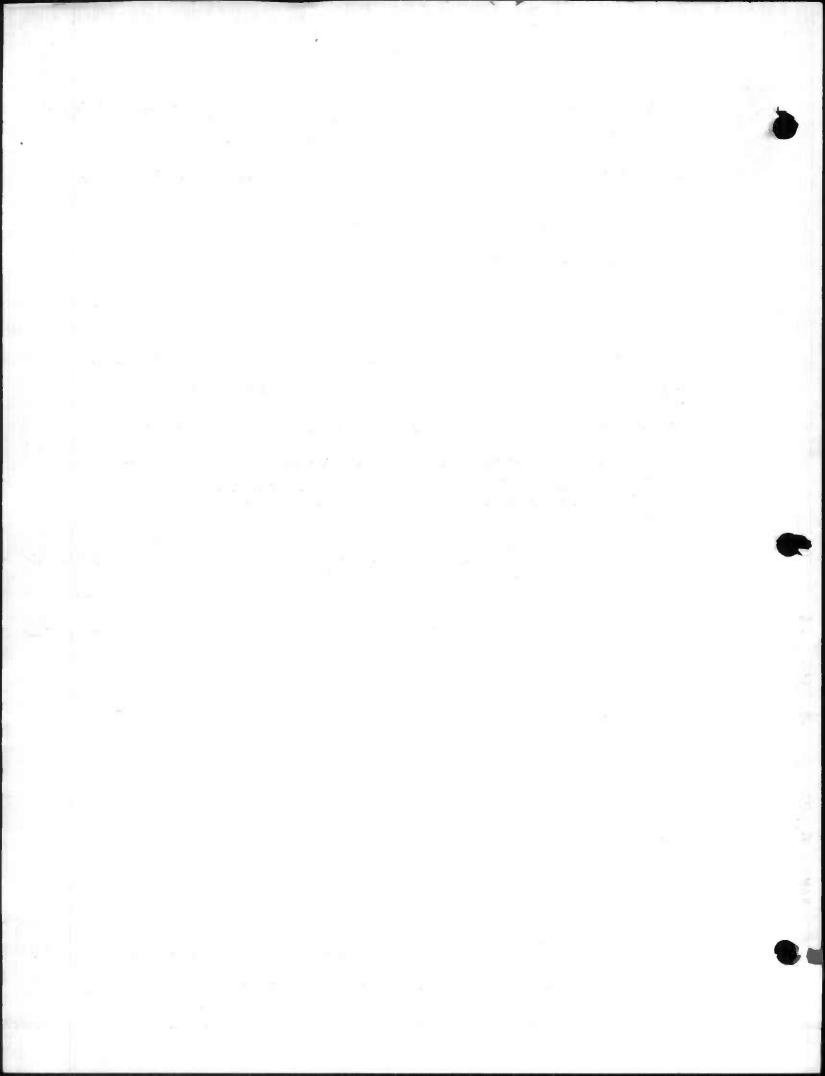
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State of Maryland / Department of Health and Mental Hygiene

27428 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** ANNA C. MALVAGNA 0 /Medical 4e. Fecility Neme (If not institution, give street end number) City, Town, or Location of Death 4c. County of Deeth Examiner MOI 5. Sociel Security Number 6. Sex It Under 1 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, Yeer) Birthplece (Stete or Foreign Country)
 NEW YORK **Funeral** Months Deys Hours 1 M 2 F 129-07-7539 Yrs. 86 Director APRIL 4,1911 Usuel Residence of Decedent 10a Stete 10b. County 10c. City. Town or Location ir than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 10d. fnside City Limits X Yes 2 No Director MD n/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3300 BENSON AVENUE "333" 21227 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 14. Race - American indien. Bleck, White, etc. filed within 72 hours efter Hygiene. 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE þ 3 ♥ Widowed 4 Divorced Yeer or Datas: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed wit Depertment of Health and Mentel Hygiens Important: If item 27 is marked other tha any fujury or other traumatic svent, that ODGs. 3RD GRADE HOMEMAKER HOMEMAKING 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) JUSTO CARLINO FILIPPA GUCCIONE 19e. informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSEANN WARNS (DAUGHTER) 7934 WOODED GLEN COURT - PASADENA, MD 21122 Baltimore. 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Ramovel from Stete cemerary, cremerary or other piece)
4 Donation 5 Mothar (Specify) ENTOMBMENTLORRAINE PARK MAUSOLEUM 9/16 BALTIMORE 22. Name end Address of Fecility
HUBBARD FUNERAL HOME INC. annon 4107 WILKENS AVENUE-BALTIMORE, MD 23e. Parf. Entar tha disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, stack, or heart teilura. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Dua to (or as a consequenca of): Examiner MOMIA physicien and the buriel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disaasa or injury that initiated avants Dua to (or as e consequence of): Sema Physician/Medical Due to (or es e consequence of) resulting in deeth) Lest 58 USB the Part il. Other significant conditions contributing to deeth but not resulting in the undarlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Propebly 4 Unknown roke à 24b. Were autopsy tindings aveilebie prior to completion of causa of death? 24a. Wes en eutopsy performed? Completed this cartificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Jivision of Vital Amending Physician: director. 25. Was case ratarrad to medical Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medical Certification: To 1 Yes 2 HNO 1 Inpatient 2⊟ER/Outpetient 3□ DOA 28e. Dete of injury (Month, Day Year) 27. Mennar of Death 28b. Time of 28d. Describe how Injury occurred 28c. injury et Work? After 1 Matural 5 Pending 1 Tes 2 No 2 Accident investigation 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Sulcide 28e. Piece of Injury - At home, ferm, street, factory, offica building, atc. (Specify) 4 Homicida 29a, Certifian 1 Certifying Physician: To tha best of my knowledge, daath occurred at tha time, deta and piece, end dua to tha ceuse(s) end mannar as stated. To the Hos within 24 h To the Fun 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signeture end title of cartifian 29c. License number 29d. Dete signed (Month, Day, Year) DOS0907 30. Nema and eddress of person who completed cause ot daeth (itam 23a) (Type, Print) 16 SOUTH Meh. 14 MD 900 22. Registrars Signatura State Registrar

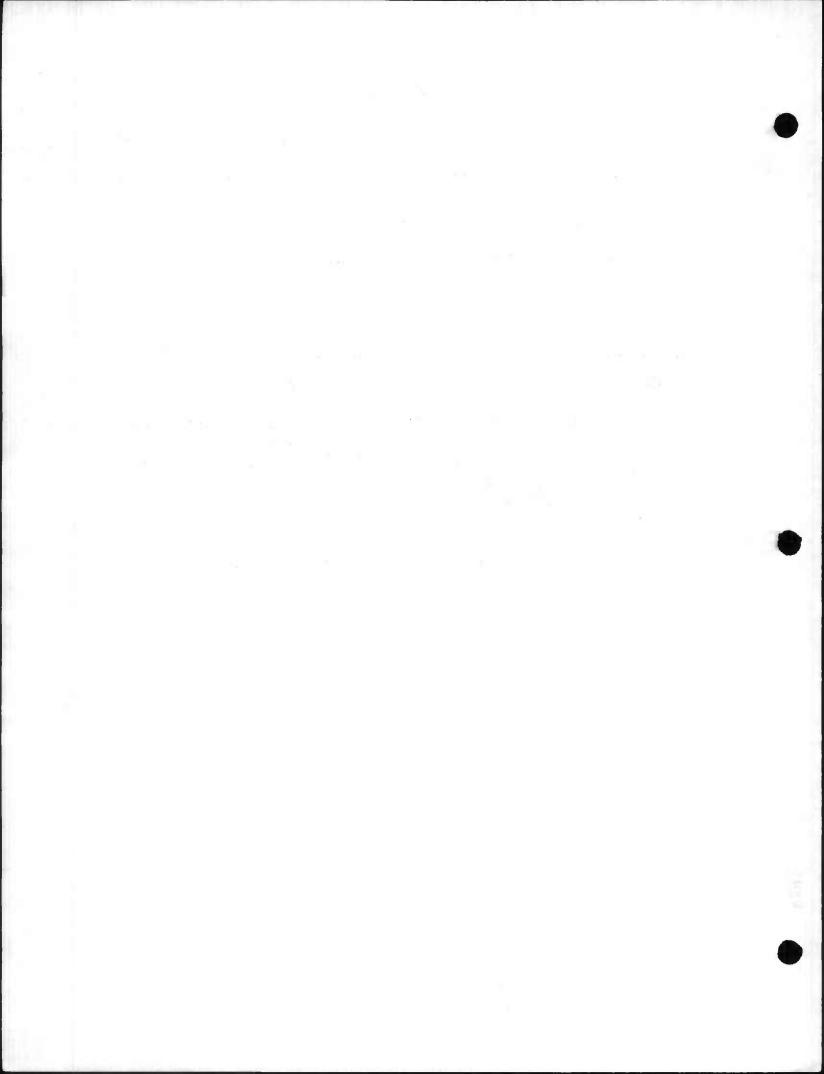
MALVAGNA

ANNA



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

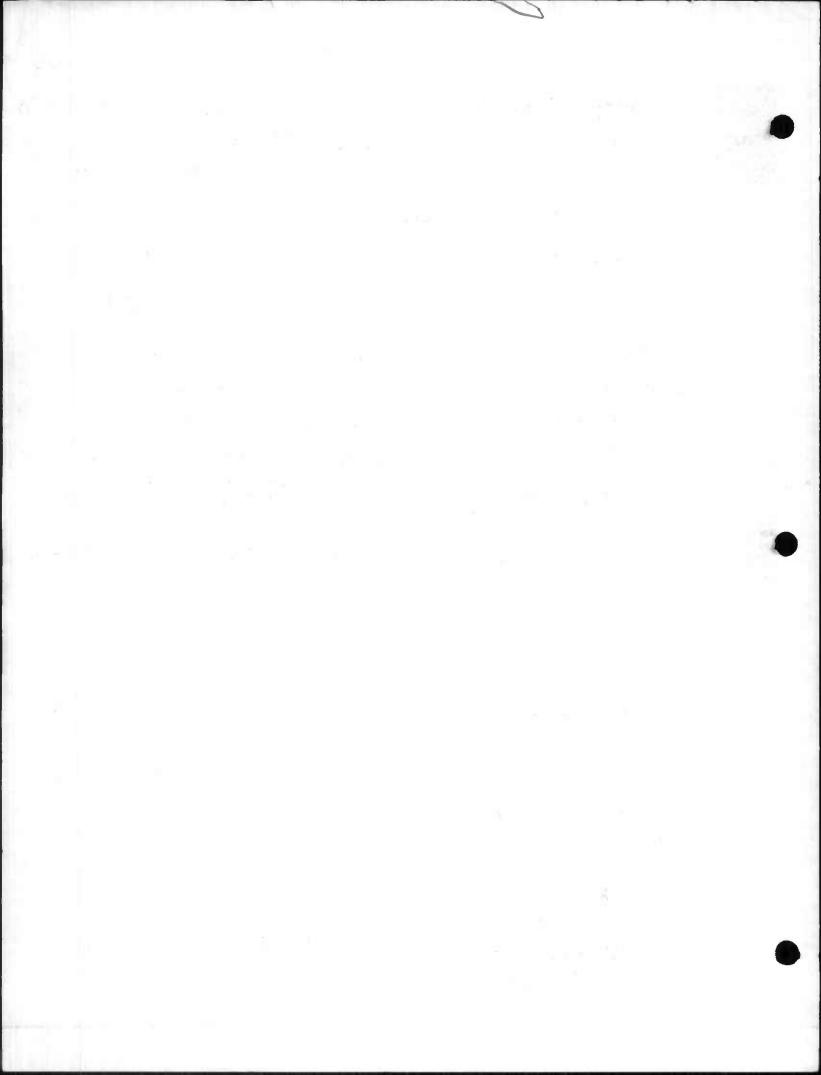
27429 Certificate of Death 1. Decedent's Name (First, Middle, Last) CHARLESEMARTIN 3. Time of Death 2. Dete of Death Month **Physician** 4:34 Pm SPP 97 /Medicai 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BALTIMORE BALTIHORE (ST. AGNES HOSPITAL 5. Social Security Number 7. Age (in yrs. lest birthdey) If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) **Funeral** 1⊠M 2□ F Days Director 220-18-5373 74 FEB.9,1923 BALTIMORE Usual Residence of Decadent the Maryland 10e State show 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 No 288-1 MD BALTIMORE CATONSVILLE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Berrie 23a or 719 MAIDEN CHOICE LANE - BR-140 U.S.A. Funeral 21228 Wes Decedent Evar In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - American Indien, Bleck, White, etc. 11. Marttel Status hours after Yes 2 No f Yes. Give 1 Never Married 2 ☐ Married 8 Baltimore, Maryland 21215-0020 1 Tyes 2 ™ No Specify Specify þ 3 Wildowed 4 Divorced WHITE 'natural', Year or Dates: Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry filed within 72: thus. Elementary/Secondary (0-12) College (1-4or 5+) 튑 12TH GRADE DESIGN ENGINEER BENDIX 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental 27 is marked of traumatic ever ROBERT MARTIN IDA MANGER Lo 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra MILDRED BERNICE KOOKE (SISTER) 719 MAIDEN CHOICE LANE-BT-140-CATONSVILLE, MD21228 20e. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece SERVICES 20c. Location - City or Town, Stete 1 ☐ Burial 2 🛣 Cramation 3 ☐ Removel from State CARROLL CREMATIONS 4 ☐ Donetlon 5 ☐ Other (Specify) 9/8/97 HAMPSTEAD, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lure. List only one cause on each line. 23a, Part1 Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel Immediate Ceuse (r diseese or condition resulting in deeth) Severe restrictive lung Disease
Due to (or es e consequence of): Examiner Physician/Medicai Examiner Pertension equiras that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Entar Undarlying Cause (Disease or Injury that initiated events resulting in deeth) Lest VAME; Division of Vital Records, P.O. Box 68760, physician s the buria Due to (or as e consequence of) USB 88 Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yaa 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed t þ 24b. Were autopsy findings evelleble prior to Completed 24e. Wes en eutopsy performed? completion of cause of death? afa has 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA this 27. Manner of Deeth Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how Injury occurred After 5 Pending Investigation 1 Natural 2 Accidant s efter death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Steta) in by 4 Homicide within 24 hours of To the Funeral (Hospital 12 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only 94 29b. Signeture and title of cartiful 29c. License number 29d. Data signed (Month, Dey, Year) N P10884 a 0 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) HOSPITAL-900 CATON AVE-BALTE, Md 21279 NAME S+. A9 NOS 38 Registrar's Signeture 31. Dete filed (Month, Dey, Year) SEP 1 0 1997 State white Savidson Randall 1 0 1997 Registrar



State of Maryland / Department of Health and Mental Hygiene

27430 Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Death **Physician** Month Mundey Dorothy 12:37PM SEDT /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ay) If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 05/09/1911 BACTONORECIT JOHNS HOPKINS BAYUKW MEDICAL 5. Social Security Number Birthplace (State or Foreign Country)
 Maryland 6. Sex 7. Aga (In yrs. last birthday) **Funeral** 1□M 2ĦF 212-10-0462 Director 86 Usuai Residance of Dacedant tha Maryland 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23a or 28a-f ahow traumstic event, the Medical Examiner must be notified at Baltimore 1 Yas 2 □ No Director MD N/A 10e. Streef and Number 10f. Zip Coda 10g. Citizan of What Country? 120 S. Bouldin Street U.S.A. Funeral 12. Was Dacedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ঐ No If Yes, Giva Yaar or Dafes: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whife, etc. permit. Pagas 1 and 2 should be filed within 72 hours after to Department of Health and Mertial Hygiene. Important: If item 27 is marked other than "natural", or file any injury or other traumatic event, the Medical Evan 1 ☐ Never Marriad 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: by Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elemantary/Secondery (0-12) Collega (1-4or 5+) C & P Telephone Co. Utility 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Ludwig Kaiser Josephine Kessler 19e. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 8916 Parlo Road Baltimore, Maryland Carol Owings/ Niece 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cramation 3 ☐ Ramoval from Stata 9/9/97 Beltsville, MD 4 ☐ Donation 5 ☐ Othar (Specify) Chesapeake Crematory 21 Signature of Funaral Sarvice Licenses 22. Nama and Address of Facility
Moran-Ashton-Dabrowski Funeral Home, 3000 E. Baltimore St. Baltimore, MD 21224 wia 23a. Part1. Entar tha disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heert failure. List only one ceuse on each line. onsef and Death **Physician** cerebrovascular accident /Medical Immediata Causa (Final diseasa or condition resulting in daath) week Examiner that the death cartificate be axecuted Sequantially list conditions, if any, leading to Immadiata causa. Entar Underlying Causa (Diseesa or Injury that initiated evants rasulting in daath) Last and Dua to (or as e consequence of): Records, P.O. Box 68760, attanding physician for usa as tha buria Physician/Medicai Dua to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? á 1 Yss 2 No 3 Probably 4 Unknown Pneumonia þ 24a. Was an eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed 1 Yas cardificate Division of Vital the Hospital or Attending Physician: 25. Wes case rafarred to madical axaminar? director Be 26. Placa of Death (Check only one) Othar: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA After this 27. Mennar of Daath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation daath. 1 Yas 2 No d in by that 3 Suicide 6 Could not be datamined 28a. Placa of Injury - At homa, farm, straef, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral DI complately filled in 29a. Cartifian 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) and menner es stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signature and fittle of certifian 29c. License number 29d. Date signed (Month, Day, Year) 30. Nama and address of parson who completed causa of daath (Item 23e) (Type, Print) Johns Hopkins Bayview Medical Center Mathews Gregory 4940 Eastern Ave. Baltimore, MD MD 31. Date filad (Month, Day, Year) 32. Registrer's Signatura State Registrar 0 1997



97-5084-510 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. B.K.S State of Maryland / Department of Health and Mental Hygiene DAVID MOORE JR. Items:23a part I,27,28a-f per MEO G-751 9/20/97 dh Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 6, 1997 LAVID J. MOORE SEPT. /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 2000 O'DELL AVENUE APT.#816 BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 3 - 29 - 6 **Funeral** Sex 1 D M 2 □ F Days 219-80-6349 Usual Residence of Decedent 32 Yrs. Director 10b. County 10a. State 10c. City, Town or Location 3ALT, MOKE Directo Md-N the 10e. Street and Number 10g. Citizen of What Country? 6 mult be 1225 LyzBRINE 4.5,1 2/2/3

13. Wes Decedent of Hispanic Origin? (Specify Yes or Noif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Items 23a 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. The Medical Examiner 1 Never Married 2 Married 1□ Yes 2□ No Baltimore, Maryland 21215-0020 6 Specify: BLACK by 3 ☐ Widowed 4 ☐ Divorced 'netural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) iges 1 and 2 should be filed within it of Health and Mental Hygiene. If them 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) SECYRITY WELL PARYU 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname Be DAVID Shirley HARVE MOOKE 19b. Mailing Address (Street end Number or Rural Route Number, City or Yown, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) TANGER LA
20a. Method of Disposition REMME/ AVE. BALLO. And. 2/206 Date 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or 9/13/92 BAHO, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Brundway Balte mel 21213 21. Signature of Funeral Service Licensee JEFF MILLER P.C. FUNERAL HOME + SERVICE disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, to heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Finat disease or condition resulting in death) AMITRIPTYLINE INTOXICATION Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to Immediate ceusa. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Last end Dua to (or as a consequence of): Box 68760 physician Due to (or as a consequence of) Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco was contribute to the cause of death? P.0.

Physician/Medicai þ Completed Be

Certification: To

signed by t

Records,

Division of Vital

To the Hospital or Attending Physicien: within 24 hours after deeth.

To the Funerel Director: After this certifica

25. Was case referred to medical

29b, Signature and title of certifier

31. Date filed (Month, Day, Year) SEP 1 0 1997

Yes 2□ No

27. Manner of Death

1 Natural

2 Accident

4 Homicide

3 Suicide

29a. Certifier

Hospitat: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 9/6/97 6XX Could not be determined

1 ☐ Yes 2/(X) No unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found in apartment

Other: 4 Nursing Home XX Residence 6 Other (Specify) 28d. Describe how Injury occurred unknown 28f. Location (Street end Number or Rural Route Number, City or Town, State) 2000 0 Dell Ave.,

24a. Was an autopsy performed?

26. Piace of Death (Check only one)

Baltimore, Md. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

> 29d. Date signed (Month, Day, Year) SEPT. 7, 1997

1 Yss 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to

completion of cause of death?

2 No

0750 AM

10d. Inside City Limits 1 PYes 2 No

Onset and Death

who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

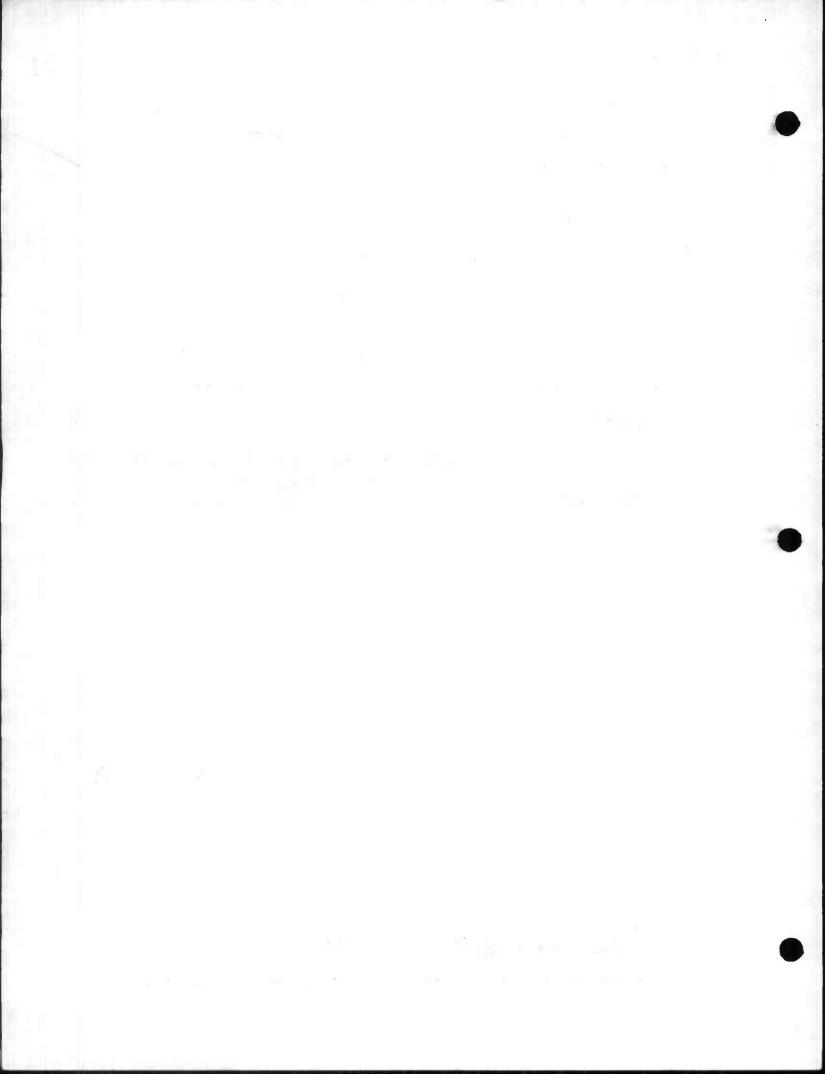
29c. License number

O.C.M.E

State Registrar

Medicai

RON Locke

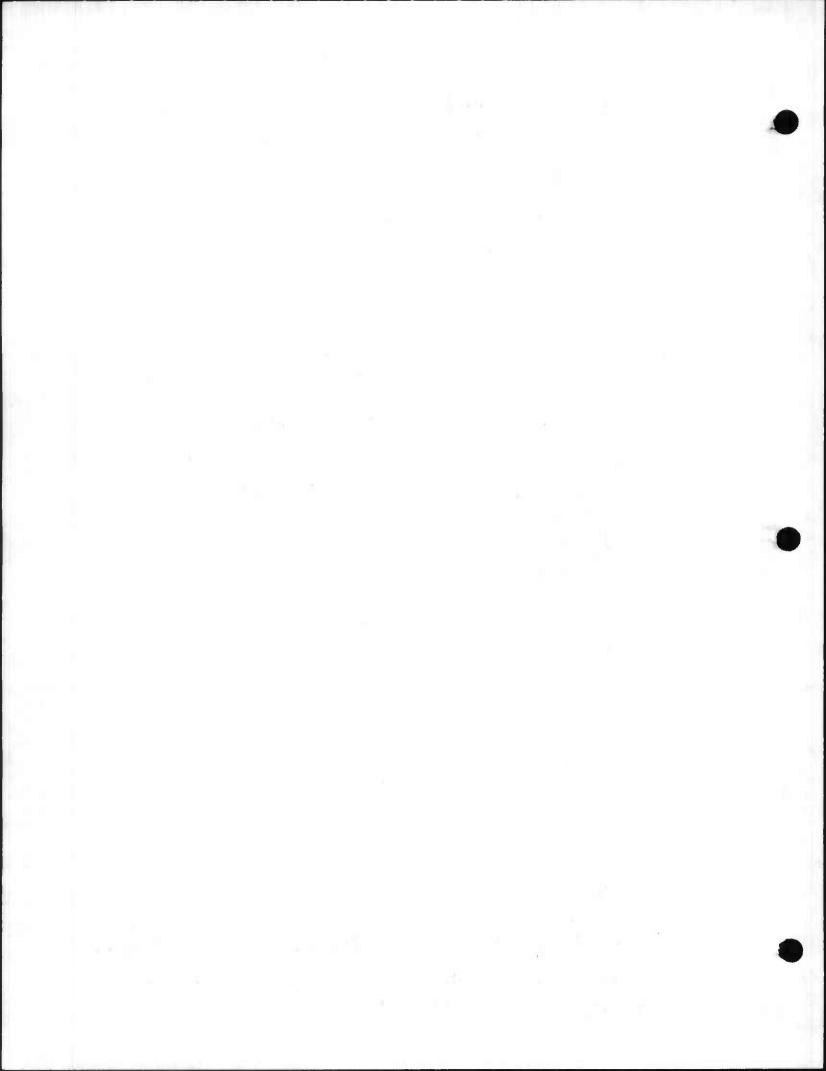


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | | | | - | Cen | tificate of | Death | | Reg. No. | 1 6 | - 14 | 32 |
|-------------------|---|----------------|--|--|-------------------------------|--|---|--|---|--------------------------------|------------------------------------|---|------------------|
| | | | Decedent's Neme (First, Middle, La | | | | | | 2. Dete of De | ath | Vess | 3. Time o | of Death |
| | Physici /Medi | | JAMES | NORRIS | | | | | Septem b | Day 9 | Year 1947 | 2.30 | D AM |
| | Examir | | 4e. Fecility Name (If not institution, giv | a street and number) | | | | 4b. City, Town, o | or Location of Deeth | 4c. County | of Deeth | | |
| | | | HAR BOR HOSPITAL CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1. Hunder 1 Year Hunder 24 H | | | | | | | 1 | I/A | | |
| | Funeral Director | | 415-54-0987 | Sex 7. Age | | rthday) Yrs. | Months Deys | If Under 24 H Hours Mi | 8. Date of Bin n. 12/18/. | 1933 1933 | 9. Birthp | olece (State ntry) | or Foreign |
| | pue * = | | Usuaf Residenca of Decedent 10a. Stete 10b. County | | 10c. City, Tow | n or Loc | ation | | | | 1 | Od. Inside C | City Limits |
| | e Mary | Director | MD ANNE A | ARUNDEL | LINT | HICU | М | | | | | | s 2 No |
| | with th | i Dire | 10e. Street end Number 11 BOULEVARD PLA | ACE APT B | | | 10f. Zip Code 21090 |) | | 10g. Citizen of | Whet Cour | itry? | |
| | Jeath Tre 2: | Funeral | 11. Marital Status | 12. Wes Decedent E | ver in U,S. | 13. W | as Decedent of | Hispanic Origin? | (Specify Yes or No | | e - Americ | an Indien, | |
| 020 | 72 hours after death with the Marylend netural; or Nems 23s or 28s-f show olds! Examiner must be notified at | by | 1 Never Merried 2 Married 3 N Widowed 4 Divorcad | Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Yeer or Detes: | o | | Yes, specify Cub ☐ Yes 2 XNo | Specify: | erto Rican, etc.) | | Black, White, etc. Specify: WHITE | | |
| 5-0 | 72 hours "netural", | eted | 15. Decadent's Ed (Spacify only highast gra | ducation ada completad) | 16a | Decede | ent's Usuel Occu | petion during most of w | rorkina | 16b. Kind of B | usine <i>s</i> s/ind | dustry | |
| 21215-0020 | within ene. than | Completed | Elementery/Secondary (0-12) | College (1-4or 5- | | lifa. D | O NOT usa ratire ENANCE | od) | | RYDE | ER TR | UCK | |
| br | A F | Bec | 17. Fether's Neme (First, Middle, Last, |) | | | | 18. Mother's N | ame (First, Middle, | | | | |
| /lar | 0 0 0 | To E | LOUIS NORRIS | | | | | JULIA : | ELIZABETH | H DEATON | | | |
| Maryland | and and am | | 19a. Informant's Name/Reletionship (| **** | | | | | Rural Routa Numb | | Stata, Zip | Code) | |
| | s 1 and 3 if Health itam 27 I | | BRENDA ROUTH/STEE | P-DAUGHTER | - | | | AVE. FR | EDERICK, | | | | |
| Baltimore, | Pages 1 ament of Hea ant: If itam ury or othe | | 20e. Method of Disposition 1. Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specification) | camata | ry, cram | ition (Name of atory or other pla N MEM. (| | Date 9/12/97 | 20c. Location | | | MD | |
| Balt | permit. Pages Department of Important: If it any Injury or once. | | 21. Signature of Service Liger | | | ST | | ASHTON F | UNERAL HO | | | 1228 | |
| | | | 23e. Pert1. Enter the disease, or com- shock, or heart failure. List only | that caused | the death. Do | | | | | | | Approxime Intervel Be | ete |
| | Physician /Medical Examiner | er. | Immediate Cause (Finel disease or condition resulting In death) | . Care | dio pulm | onar | u arre | | | | 1 | Onset end | Death |
| Т | ned insit | Examiner | | b. Acu | ite M | 1400 | ardial | Infarct | tion | | | | |
| 90, | oe exect | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury | | Due to (or es e | consequ | enca ot): | | | | | | |
| x 68760, | death certificate be executed a strending physician end d for use as the bunal-transit | Medical | thet initieted events resulting in death) Lest | | ue to (or as e | consequ | ence of): | | | | | | |
| 80 | eath cert attendin I for use | Physician/I | | d | | | | | | | | | |
| 0 | g d | ysic | Pert II. Other significant conditions of | ontributing to death bu | t not resulting i | n the und | derlying cause gi | ven in Part i. | 23b. Did | tobacco use co | ntribute to | the cause | of death? |
| 4 | | by Ph | Anox | ic Ence | phalopa | thy | | | 10 | Yes 2□ No | 3 Proi | bably 4 | →Onknown |
| of Vital Record | aw meriti Is been in 2 should b | Completed | | | | - (| | | | an autopsy ermed? | av | ere autopsy eilable prior mpletion of death? | to |
| æ | The law ate has p | E O | | | | | | | 10 | Yes 2 No | 10 | Yes 2 | 240 |
| ita | | Be | 25. Wes case referred to medical exeminer? | | | | | 26. Plece of D | eath (Check only o | one) | 1 | | |
| 7 | 2 00 | ၉ | 1 ☐ Yes 2 ☑ No | Hospitel: 1 Inpatier | | utpatient | 3LI DOA | | Home 5 Resid | denca 6 □Oth | er (Specif | y) | |
| Division (| To the Mospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | Certification: | 27. Manner of Deeth 1 Neturel 5 Pending 2 Accident Investigation | | | Time of njury | 28c. Inju Wo M 1 | nyat ork?]Yes 2 □ No | 28d. Describe | how injury occur | red | | |
| Divis | al or Att | Sertific | 3 Sulcide 6 Could not be determined | | ry - At home, fa (Spacify) | ırm, stre | et, fectory, office | | 28f. Location (City or Tol | Streat and Numi vn, State) | ber or Rura | il Routa Nur | m <i>ber</i> , |
| | To the Hospital within 24 hours a To the Funeral I completely filled | edical | 29a. Certifier (Check only one) 1 ☐ Certifying Ph | yalcian: To the best of niner: On the basis of end menner stet | examination en | dor Inve | occurred et the to estigetion, in my | ime, date end ple opinion, death oc | ce, and due to the curred at the time, | cause(s) and modate and place, | anner as s and due to | the cause | (s) |
| | To th within To th | W | 29b. Signeture end title of certifier | | | | 29c. Licen | se number | | 29d. Date signe | | | |
| | | | AHMAD J KHAL | IFA, INTE | RN | | A | 52447416 | | Septemb | er - 9 | - 199 | 7 |
| | SIVA | | 30. Neme and address of person who | completed cause of de | ath (Item 23a) | (Type, P | rint) | A 2201 | South Han | | | - | |
| | Sta | ite | AHMAD J KHALII 31. Dete filed (Month, Day, Year) | 32. Registra | r's Signeture | | LENIE | , 2001 | - WID WALL | 701 | | | |
| | Registr | ar | SEP 1 0 1997 | The Devideo | Randal | 2 | | | | | | | |

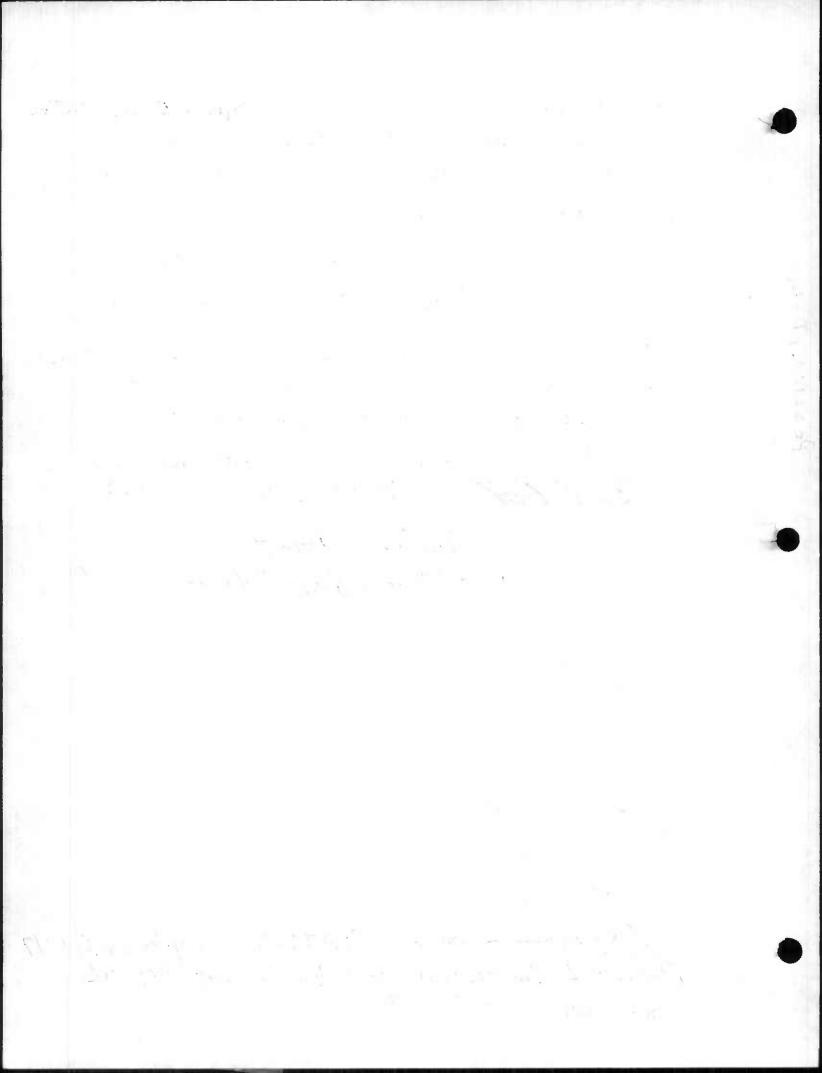
State of Maryland / Department of Health and Mental Hygiene 07 27122

| | | | | | | Cer | tificate of | Death | | Reg. No. | 1 | 21433 |
|------------|---|--------------------|---|--|------------------------------|----------------------------|--|---|--|--|----------------------------|---|
| П | Physic | ian | 1. Decedent's Name (First, Middle, La | ast) | 0) 11 | | | | 2. Date of De Month | ath Day | Year | 3. Time of Death |
| и | /Med | | Rita | | Plott | | | | Septem | hr 5 | 1447 | 10215 A |
| j. | Exami | ner | 4a. Facility Name (If not institution, gir | | | | | | r Location of Deat | 101 000111 | y of Death | |
| | | | Stella Maris at | | | | | Balti | more | N, | /A | |
| | Funeral Director | _ | | Sex 1 ☐ M 2 ☑ F | Age (In yrs. la 78 | st birthday) Yrs. | If Under 1 Year Months Days | Hours Mi | s. 8. Date of Bir (Month, De Sept. 3 | th y, Year) , 1919 | 9. Birthp Cour Ohuc | place (State or Foreintry) |
| | yland | | 10a. State 10b. County | | 10c. City, | Town or Lo | cation | | | | 1 | Od. Inside City Limi |
| | Mar | ţ | Maryland | N/A | | Ва | ltimore | | | | | 1 Yes 2□N |
| | or 28 | je je | 10e. Street and Number | | | | 10f. Zip Code | | | 10g. Citizen of | What Cour | ntry? |
| | th wil | <u>e</u> | 524 N. Charles S | t. Apt 1 | 502 | | 2120 | 01 | | u. s. | Δ | |
| 2 | within 72 hours after death with the Maryland ene. then "netural", or frems 23s or 28e-f show is Medical Examinet must be noticed at | y Funeral Director | 11. Maritai Status 1 Never Married 2 Married | 12. Was Deceder Armed Force: 1 Yes 2 | nt Ever in U,S s? | - 11 | | Hispanic Orlgin? (ean, Mexican, Pue | Specify Yes or No erto Rican, etc.) | - 14. Ra | ce - Americ ack, White, | etc. |
| 71213-0020 | ural. | d by | 3 ☐ Widowed 4 🕱 Divorced | Year or Dates | S: | | | | | Specii | whi | ite |
| 2 | "natur | Completed | 15. Decedent's E (Specify only highest gra | ducation ade com <i>pleted)</i> | | 16a. Deced (Give) | ent's Usuai Occu kind of work done OO NOT use retire | pation during most of w | orking | 16b. Kind of 8 | usiness/Ind | dustry |
| Z | withir shen | a m | Elementery/Secondary (0-12) | College (1-4o | r 5+) | | | | | | | |
| A | tygie ther rrt, II | | 12th Grade 17. Father's Name (First, Middle, Last | h | | St | tenograpi | | | | ospit | al |
| Maryland | d 2 should be filed within th and Mental Hygiene. 7 Is marked other than treumatic event, ma.M. | Be | Herbert Plott | , | | | | | ame (First, Middle, | | ne) | |
| | d Me d Me nark | 2 | | | | | | | en O'Boya | - The state of the | | |
| 2 | | | 19a. Informant's Name/Relationship (| | , | | | | Rural Route Number | | | |
| n i | and the sale | | Mary Eleanor Bigg 20a. Method of Disposition | gs (Niec | | 154 N | ition (Name of | d Avenu | e, Baltin | | | |
| Daiminore, | it of or o | | 1 Burial 2 ☐ Cremation 3 ☐ | | 6 | | sition (Name of atory or other pla | | Date | 20c. Location | | |
| | tmer tant | | 4 ☐ Donation 5 ☐ Other (Specif | | Mosa | | Redeeme | | 18/97 | Baltimo | ire, 1 | Maryland |
| ğ | permit. Pages 1 and Department of Health important: if Item 27 any Injury or other to once. | | 21. Signature of Pigreral Service Lices | Lui | | Sc. 33 | Name and Address himunek 31 Brehn | Funeral | Home Inc Baltimo | o Mari | uland | 21213 |
| | | | 23a. Part1. Enter the disease, or coushock, or heart failure. List or | ations that cause | ed the death. | Do not ente | r the mode of dyi | ng, such as cardi | ac or respiratory a | rest, | ruriu | Approximate Interval Between |
| 5 | Physician /Medical Examiner | 16 | Immediate Cause (Finel disease or condition resulting in deeth) | a | | M/tas | | Lung | Curu | | | 6 months |
| | and transit | Examiner | Sequentially list conditions, | b | Due to (or a | as a consequ | uenca of): | | | | | |
| ,00,00 | icata be executed physician and s the burial-transit | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events | c | Due to (or a | s a consequ | enca of): | | | | | |
| 20 400 | the death certificate be executed y the attending physician and ched for use as the burial-transit | n/Medical | resulting in death) Last | d | | | | | | | | |
| | death | icla | Part II. Other significant conditions of | ontributing to death | but not result | log in the un | dorhina causo ah | on In Cart I | 22h Dida | ahaaa uu | | Ab |
| | that ed b | by Physiclan/ | , arti. Otto agrincant conditions | orithouting to death | Dut not result | ing in the un- | derlying cause gr | ven in Part I. | | yes 2□ No | 3 Prot | the cause of deati |
| | as been signe | Completed b | | | | | | | | an autopsy med? | ava | ere autopsy findings ailabie prior to mpletion of cause death? |
| | age h | E | | | | | | | 101 | es 2 No | | Yes 2 No |
| 1 | | a | 25. Was case referred to medical | | | | | 26 Place of De | eath (Check only o | | | 2010 |
| 1 | 是人性] | 0 | examiner? | Hospital: 1 ☐ inpat | tient 2 TF | VOutpatient | 3 DOA Oth | or | Home 5 Resid | - | ner (Specify | , hospice |
| 1 | | - | 27. Manner of Death | 28a. Date of In | jury 2 | 8b. Time of | 28c. Injui | | 28d. Describe h | | | ,, |
| | 1 × 5 | atlo | 1 Natural 5 Pending investigation | (Month, D | ay Year) | Injury | | k? Yes 2∐No | | | | |
| | after des Director d in by the | Certification: | 3 Suicide 6 Could not be determined | 28e. Placa of Ir | njury - At homete. (Specify) | e, farm, stre | et, factory, offica | | 28f. Location (S City or Tow | Street and Numb n, Stete) | per or Rura | I Route Number, |
| | within 24 hours To the Funeral completely filled | edical | 29a. Certifier (Check only one) | yalclan: To the best niner: On the basis of and manner s | of examinetion | edge, death on and/or inve | occurred at the tirestigation, in my o | ne, date and plac pinion, death occ | e, and due to the durred at the time, d | cause(s) and ma date end plece, | anner as st and due to | ated. the cause(s) |
| 1 | within 2 To the complete | Me | 29b. Signature and title of certifier | | | 7 | 29c. Licens | e number | | 29d. Date signe | d (Month, I | Dey, Year) |
| . ' | 0 | | Del a Im | 1 no | | | Nu | V 2 7 V | | al | 5/ | 7 |
| | 00 | | 30. Name and address of person who | completed cause of | death (Itam 2 | 3a) (Tuna C | 1 | 7677 | | -1/ | 3/9 |) |
| | 14 | | Mercy Medi | | | | | no Ral+ | imaka II | aruland | | |
| | Sta | te | 31. Date filed (Month, Dey, Year) | 32 Physis | Davidson | 9 40 - | and Fill | ce, buil | MILLE, MI | wigiuna | | |
| | Registr | | SEP 1 0 1997 | Store | Wavidson | n-Hande | اللات | | | | | |



State of Maryland / Department of Health and Mental Hygiene 97 27434

| | | | | | Cei | rtificate of | Death | Re | g. No. | , , | 61404 |
|--|------------------|---|---|--|--------------------------|---|--|--------------------------------------|-------------------------------|--------------|---|
| Division | | Decedant's Name (First, Midd | fle, Last) | | | | | 2. Data of Deeth | 1 | | 3. Time of Death |
| Physic /Medi | | PETER FRANK | PEZZICA | | | | | September | Dey 5 | 1997 | 10:57 Am |
| Exami | | 4e. Facility Nema (if not institution | on, giva street and num | nbar) | | | 4b. City, Town, or | Location of Deeth | 4c. Count | | |
| The same | | Fallston Gene | ral Hospita | il | | | Fallston | | Harf | ord | |
| Funeral | г | 5. Sociel Security Number | | 7. Aga (In yrs. la | st birthday) | If Undar 1 Yee Months Days | | | Vearl | 9. Birth | placa (Stata or Foreign ntry) |
| Director | | 212-10-7074 | 102M 2□ F | 85 | Yrs. | Months Days | S FIGURA WIII | 11-30-1 | | | uland |
| pue * | | Usual Rasidanca of Dacadent 10a. Steta 10b. Count | , | 10c City | Town or Lo | cation | | | | | 40d In state Other Liveries |
| /anyle | 5 | Maryland Harfo | | | | 10d. Insida City Limits 1 ☐ Yas 2 ☐ No | | | | | |
| the A | Director | 10e. Street and Number | | | el Ai | 10f. Zip Coda | | 140 | - 0000000 | | |
| with with | | | /11 | | | | | 10 | g. Citizan of | | ntry? |
| leath 23 | Funeral | 616 Beretta 11. Marital Status | | dant Ever In U.S. | 13 \ | 21015 | | Specify Vac or No. | U.S.A. | | can indien, |
| 7 C Her her her her her her her her her her h | E | 1 Navar Married 2 Mai | Armed For | cas? | +0 | | Hispanic Origin? (S ban, Maxican, Puar | to Rican, atc.) | | ck, Whita, | |
| ind 21215-0020 be filled within 72 hours effer death with the Maryland tall Hyglene. I other than "natural", or items 23a or 28a-1 show event, the Medical Example must be nothing a | by | 3 ☐ Widowed 4 ☐ Divorce | If Vac Civi | 2 □ No 1 9 4 1 ates: 1 9 4 5 | to | 1□ Yas 2021 No | Specify: | | Specif | y: Wh | ite |
| O O O | Completed | 15. Dacada | nt's Education | | 16a. Daced | lant's Usual Occu | pation | 1 | 6b. Kind of B | lusiness/In | idustry |
| 211 211 21 21 21 21 21 21 21 21 21 21 21 | pje | Elamantary/Secondary (0-12) | est grada complated) Coilage (1- | 4or 5+) | lifa. l | kind of work done DO NOT usa ratin | during most of wo | rking | | | |
| 212 212 ad withingiene. | 9 | 8 yrs | | | ware | chousema | n | | Retail | 2 Fur | niture |
| ind ind ind dother went, | Be | 17. Father's Name (First, Middla, | | | | | 18. Mother's Ne | me (First, Middle, M | laidan Sumar | ne) | |
| laryland 212. 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, fro. In. | 2 | | zica | | | | Rose | | | Sola | |
| 00000 | | 19a. Informant's Name/Ralation | | | | | | ural Routa Number, | | , Steta, Zip | Coda) |
| other tra | | Helen M. Pezzi | ca-wife | | | | | Air, Md. | | | |
| Baltimore, semit. Pages 1 er appelment of Hea mportant: If item 3 my night or other night or other night. | | 20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation | 3 Ramoval from S | tate 205. Pla | na <i>tery, cr</i> an | sition (Nema of natory or other pla | eca) | Deta 2 | Oc. Location | - City or To | own, Stata |
| timer timer thant: | | 4 □ Donation 5 □ Other (5 | | High | | Memoria | | -8-97 | Falls | ton. | Md. |
| Baltimore, N pemil. Pages 1 and 1 Department of Health Important: If New 27 I any Injury or other to | | 21. Signeture of Fundal Service | Licansee | - | 22 | Nama and Addr | ass of Facility | Hama al | ROP A | . T | 10.0 |
| _ 402.00 | | " Ma | 10 | | 6 | 510 W. M. | acPhail R | Home of Rd. Bel Ai | r. Md. | 210 | 14 |
| | | 23a. Part1. Enter tha disaasa, o shock, or haart failura. Lis | r complications that ca l only one ceusa on as | used tha daeth. ich line. | Do not anti | ar tha moda of dy | ing, such as cardia | c or respiratory arra | st, | | Approximata Intarval Batween |
| Physician | | | | 1 | 1 | . / | 1 | + | | | Onset and Death |
| /Medical Examiner | | Immediata Causa (Finel disaasa or condition resulting in daath) | a | Car | 410 | ec c | Tres, | | | 1 | |
| 100 | Į. | To be the second | 0. | Due to (or a | s a conseq | uenca of): | 1 1 7 | favet | , - | | 11. |
| nsit n | 듣 | | b. U.C. | ule " | uyo | cara | ree h | ntanct | non | | , we |
| Box 68760, eath certificate be executed ettending physician and for use as the burketrensit | Medical Examiner | Sequentially list conditions, if eny, laading to immadiata causa. Entar Underlying Causa (Disaasa or Injury that initieted avants | 50.00 | Dua to (or a | s a cohseq | uance of): | | / | | | |
| 68760, flicate be ex physician as the burie | ca | Causa (Disaasa or Injury that Initieted avants | c | Due to for a | | | | | | | |
| 68 Hicat g phy as th | Pa | resulting In death) Lest | | Dua to (or a | s e consequ | uance or): | | | | | |
| OX n cert | | | d | | | | | | | | |
| Acords, P.O. Box | Physician | Pert II. Other significant condition | ons contributing to dea | ith but not resulti | no in the ur | darlying cause o | ivan in Part I | 23h Did toh | 19000 HBB 00 | mtelburte t | o the cause of death? |
| o.O. of the dathe tached | hys | | | | | idatifung daddo g | | | | | bably 4 Unknown |
| S the se the be de | by F | | | | | | | | 20110 | 00110 | Daby 4 Onkilowii |
| D on a pinc | | | | | | | | 24e. Was an | autopsy | 24b. W | ere autopsy findings reliebla prior to |
| Share Share | piel | | | | | | | parioni | ear | CO | mplation of causa daath? |
| obad obad | Completed | | | | | | | 1 ☐ Yas | 2 No | 16 | □Yas 2□No |
| Water St | Bec | 25. Wes casa rafarred to medica | l | | | | 28. Placa of Dar | ath (Check only ona | / \ | | |
| of Vita Physician this certification | To | axaminar? | Hospital: 1 | patiant 2 EF | VOutpatient | 3□ DOA Ot | her: 4 Nursing H | lome 5 ☐ Rasidar | ica 6 🗆 Oth | nar (Specif | (y) |
| Vision of V Attending Physic Ardeath. ector Attent his co | | 27. Manner of Death 1 Natural 5 ☐ Pandir | 28a. Deta of (Month) | injury 28 Day Year) | Bb. Tima of Injury | 28c. Inju | iry at | 28d. Dascribe how | v Injury occur | red | |
| iSiO tendideath. Afor: A | catl | 2 ☐ Accidant invasti | gation | | | | Yas 2□No | | | | |
| Division of VII. or Attending Physician after deals after this certification: After this certification. In by the funeral director. | Certification: | 3 ☐ Suicida 6 ☐ Could 4 ☐ Homicida datem | ined 28a. Placa o | of Injury - At home g, atc. (Specify) | a, farm, stre | et, factory, office | | 28f. Location (Stre City or Town, | et end Numb Stata) | ber or Rura | Il Routa Number, |
| ytai o urs a contrait of the contrait of the contraint of | | | | | | | | | | | |
| Divis To the Hospital or Atte within 24 hours affected for the Funeral Director completely filled in by the | Medical | 29a. Cartifiar 1 Certifyir (Check only one) 2 Medicai | g Physician: To the b Examiner: On the bas | ils of axaminetion | dga, daath and/or inv | occurred et tha ti estigation, in my | ima, data and place opinion, deeth occu | i, and dua to tha cau | usa(s) and me a end placa, | ennar as s | tated. the causa(s) |
| the apple | Mec | 29b. Signetula and titla obertifia | and manna | ar stated. | | | | | | | |
| F. 3 F. 8 | | 7 | 1 | mi | 1 | 1 | se number | > (| d. Date signe | | |
| -2X | | 080 | | | | DO | 1331) | -) | eprev | nber | 6,1997 |
| 10 | | 30. Marine and addrass of person | wno completed causa | or daath (Itam 2: | (Type, F | Fallo | ton Co | eneral | 1000 | month | L |
| Sta | te | 31. Data filad (Month, Day, Year) | | | | | UN O | | , - 3/ | , , | |
| Registra | | SEP 1 0 199 | 7 guine | glstrar's gignatur | Martinga | - | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Deeth 3. Time of Death JOYCE GPUMPHREY Month SEPTENBER 03 1997 10:04 P.M 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death HOSPITAL CENTER BALTIMORE HARBOR 7. Age (In yrs. lest birthday) If Under 1 Year | tf Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 1□ M 2X F Deys Hours 70 Yrs 219-18-3542 April 20 1927 Maryland Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. toside City Limits 1 ☐ Yes 2 ☐No Delaware n/a Selbyville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 West White Tail Drive 19975 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Stetus 1 Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorcad 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b Kind of Business/Industry Eiementary/Secondary (0-12) College (1-4or 5+) 9 Maryland Cup Company 0 Machine Operator 17. Father's Name (First Middle Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) Robert Edward Wolfe Sara Murray 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Howard S. Pumphrey 12 West White Tail Dr. Selbyville, Del. 19975 (Husband) 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) Sept. 1997 20c. Location - City or Town, State 4 1 ☐ Burial 2 【**Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Cemetery Baltimore, Md. 21. Signature of Fungral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home of South Balto. 130 E. Fort Ave., Baltimore, Md. 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such time. Approximate tntervat Between Onset end Death tmmediate Cause (Final HEPATIC FAILURE 5 DAYS disease or condition resulting in death) PORTE SYS 45 DAYS TRANSJUGULAR INTRAHEPATIC TEMIC SHUNT Due to (or as e consequence of): Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 ☐ Yes all No

Physician /Medical Examiner

physician end the burial-trensit

ettending p

\$ igned by

certificate

this

After

ofrector: A

To the Hospital or within 24 hours aft To the Funeral Di completely filled in

þ 8

Completed

Be

Certification: To

Medical

that the deeth certificate be executed

P.O. Box 68760,

Division of Vital

Hospital or Attending Physician:

death.

Physician

/Medical

Examiner

Funeral

Director

28a-f show

5

or Itema 23a

naturaf,

Hygiene.

Department of Health end Mentel moutant: If item 27 is marked or

b

Injury

the Medical Examiner must be nothing at

Director

2

Completed

Be

the Maryland

filed within 72 hours efter

Baltimore, Maryland 21215-0020

Examiner Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Physiclan/Medical

Part it. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

25. Was case referred to medical

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 Yes 2 No 27. Manner of Death 1 Naturel 5 Pending investigation 2 Accident

6 Could not be determined

Hospitat: 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of tnjury (Month, Dey Year) 28b. Time of

28c. tnjury at Work? 1 Yes 2 No 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a, Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated.

29c. License number

29b. Signature and the of cartifier

3 ☐ Suicide

4 Homicide

HARBOR HOSPITAL CEN

2441614 AI

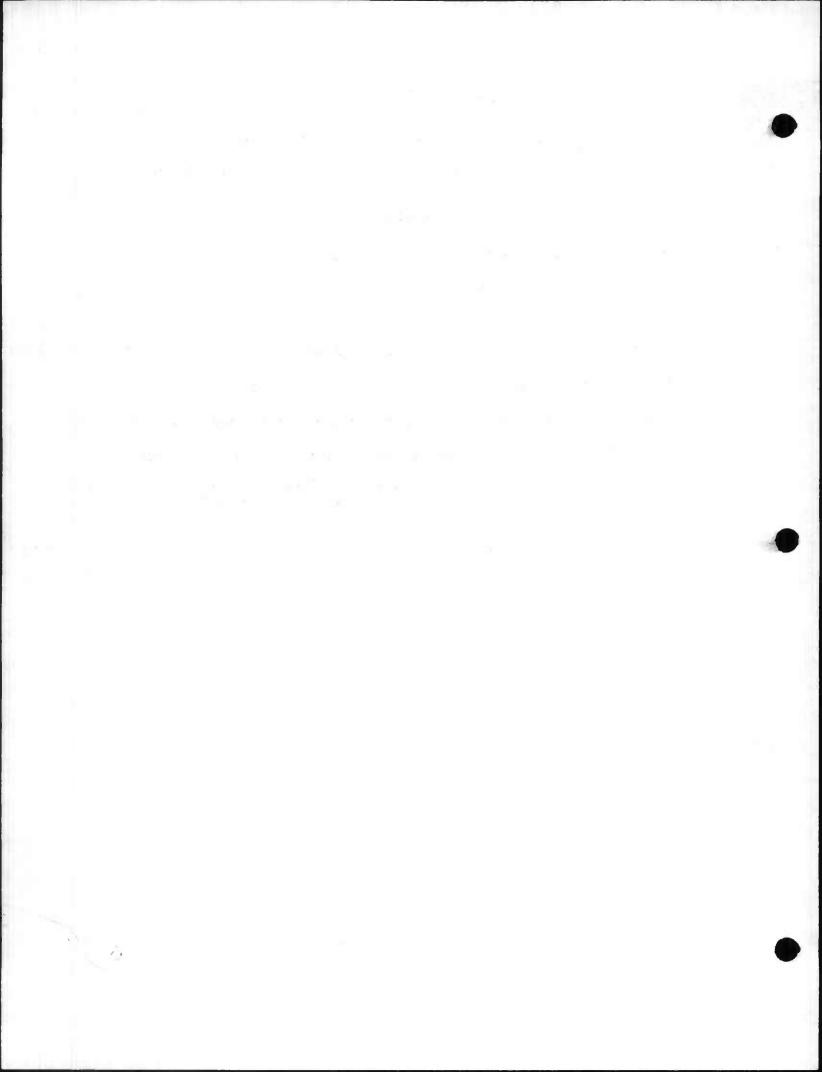
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RESIDENT

3001 HOSPITAL CENTER, BALTIMORE, MO

Registrar

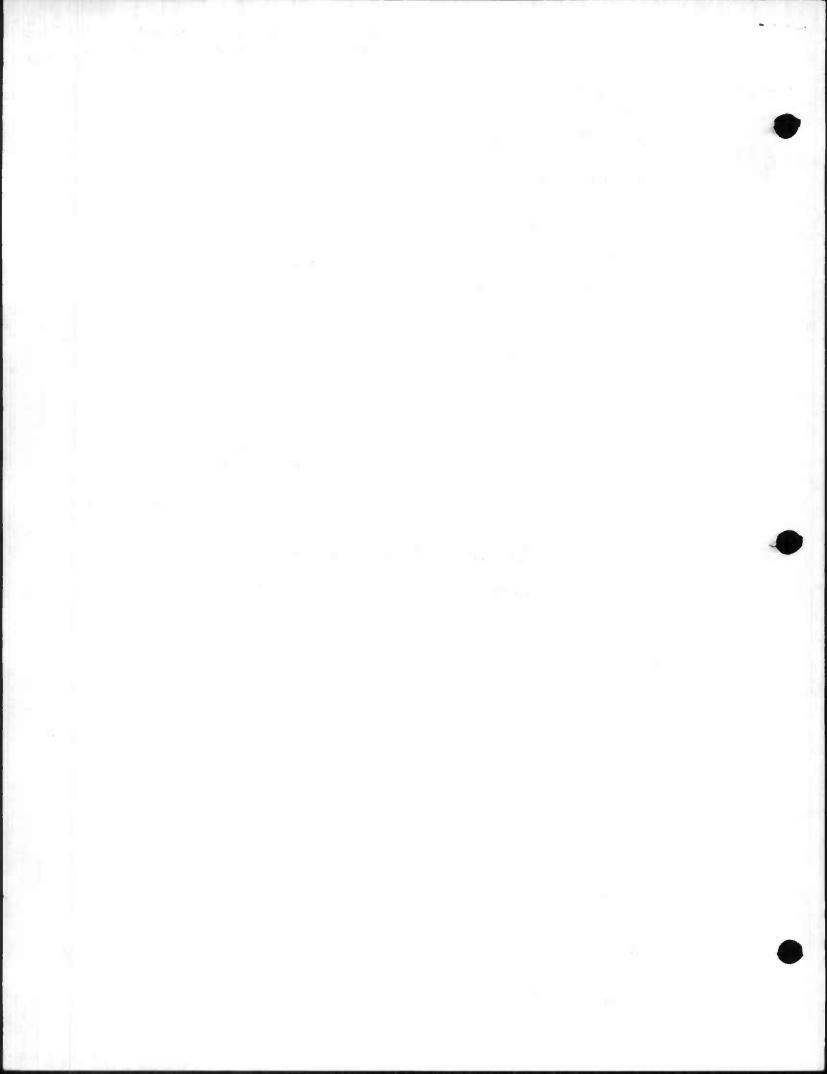
SHARIF CHOWDHURY, HARBOR 32. Pogistrar's Signature



State of Maryland / Department of Health and Mental Hygiene 97 271.36

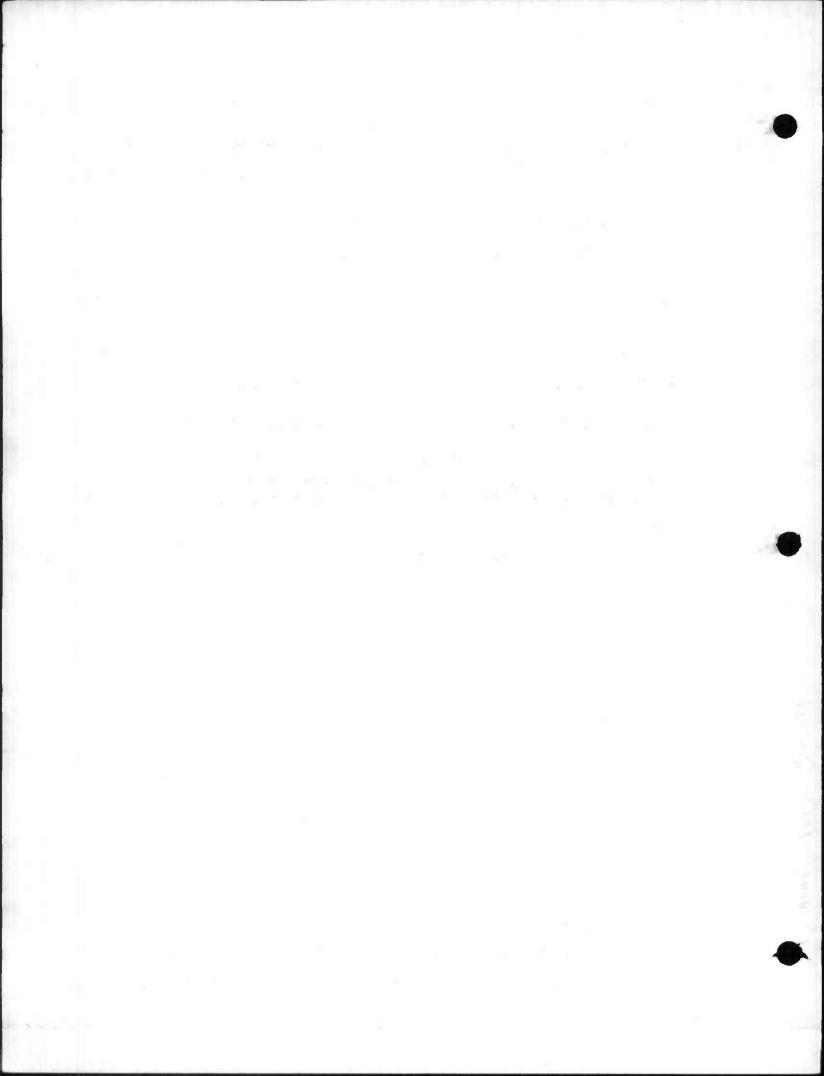
| n i r | 1. Decedent's Nama (First, Middle, Last CRMQN | Pollhein | | | 15 | 2. Date of Dea Month | ^{Day} 19 | Year 3 | Time of Death |
|--|--|--|---|--|---|--|--|--|---|
| r | MCRMAN F. 4a. Facility Name (If not institution, give Atlantic Ollie | Street and number) | | | | Sept. | 3 19 | 97 | 5:2201 |
| | 4a. Facility Name (If not institution, give | street and number) | | | | | | | Carps. |
| | ATIGNTIC COLLIE | | 1 | | 4b. City, Town, or Lo | cation of Death | 4c. County | of Death | , |
| 1 | THE COURT | Ray Hospita | U | W11-2-4-1 | BERLIN | | WO | ECHES | ter |
| 4 | 5. Social Sacurity Number 6. Sa 218-28-9320 Usual Residance of Decedent | X 7. Age fin yrs. la | | If Under 1 Yaar Months Days | Hours Min. | 8. Data of Birth (Month, Day | 1932 | 9. Birthplac Country Mary | a (State or Fore |
| - I- | 10a. State 10b. County | 10c. City, | Town or Loca | tion | | | | 10d. | Inside City Limit |
| 5 | Maguland Baltim | 1000 TOU | NOON | | | | | | 1 Yes 2.5 |
| 3 1 | 10e. Street and Number | 100 | 00019 | 10f. Zip Coda | | 1 | l0g. Citizen of V | What Country | ? |
| 2 | 11003 Pinnacho K | 20 | | 212 | 810 | | 115 | 31 | |
| 5 | 11. Marital Status | 12. Wes Decedent Ever In U,S | . 13. Wa | s Decedent of I | Hispanic Orlgin? (Spe | ecity Yas or No- | | | Indian, |
| 3 | 1 ☐ Navar Married 2 ☑ Married | 1 ☐ Yes 2 🔀 No | | | | Hican, etc.) | | | |
| 2 | 3 Widowed 4 Divorced | Year or Dates: | 1 L | JYes 2MALNO | Specify: | | Specify | WHIPE | |
| 200 | 15. Decedent's Edu (Specify only highest grad | cation (e completed) | 16a. Deceder | nt's Usual Occup | pation during most of worki | ina | 16b. Kind of Bu | usiness/Indus | y . / |
| 1 | Elementary/Secondary (0-12) | College (1-4or 5+) | life. DC | NOT use retire | d) | | Baltin | 10Re (| UY4 |
| 3 | 124RB | 8 yr8 | Haci | UR | | | | | 0 |
| Ď | Last) | | | | 18. Mother a Name | (First, Middle, | Meiden Sumam | 18) | |
| - | NURMAN MOIII | WIN | | | Bouls | ROE | nier | | |
| | SI. Alan Dallianing (1) | - 0 | 19b. Meiling | Address (Street | and Number or Hurs | CA M | r, City or Town, | State, Zip Co | de) G/ |
| 4 | MIRLLY POLINGEN | | 1603 P | innucul | RO. 10W | JON, MI | 2RYIUNC | City of Town | State |
| Ι. | 1 XBurial 2 ☐ Cremation 3 ☐ F | Removal from State | netery, creme | tory or other pla | ce) , S | lept 6 | _ | Only of Town | State |
| - | | | | rek Cen | netery | 1997 | balto. Mk | 4. | |
| | 21. Signature of Funaral Servica Licans | 86 | 22.1 | Name and Addre | ess of Facility EV | ans ch | apel of | Ken | 10RUS |
| 1 | GRESHA J. C | Wells | 88 | 00 Hay | eterd Rd | Bal | timope | Md | 21234 |
| 1 | 23a. Part1. Enter the disease, or complete ahock, or heart tailure. List only or | ications that causad tha death. ne cause on eech line. | Do not entar | tha moda of dyl | ng, such as cardiac o | or respiratory arr | est, | Ar | proximate erval Between |
| | Immediate Cause /Final | | 0. | | | | | | iset and Deeth |
| - 1 | disaase or condition | LARDIAC | 1-615 | RYTH | With | | | | |
| 5 | | · · | as e conseque | ence ot): | | | | 1 | |
| | | | 1 (27) | 2411 | | | | i | |
| | if any, leeding to immediate cause. Enter Underlying | Due to (or a | as a conseque | inca oi): | | | | 1 | |
| 3 | triet initiated events | Due to for a | as a conseque | nce of): | | | | + | |
| 2 | rasulting in death) Last | 230 10 (01 0 | | .,,,, | | | | | |
| | | | | | | | | | |
| | Part II. Other aignificant conditions cor | ntributing to death but not result | ting in the und | ertvina cause air | ven in Part I. | 23b. Did to | obacco use co | ntribute to th | e cause of dea |
| | | • | | , | | | | | |
| | | | | | | | | | |
| | | | | | | 24a. Was a | in autopsy | 24b. Were | autopsy tinding ble prior to |
| | | | | | · . | perior | 111001 | comp | etion of causa |
| | | | | | | 1 🗆 Y | es 200 No | 1 D Y | es 2 No |
| | 25. Was case reterred to medical | | | | 26. Plece of Death | | | | |
| | examiner? 1 ☐ Yes 2 ☑ No | lospitel: 1 Inpatient 2 KE | R/Outpatient | 3 DOA Oth | 365. | | | er (Specify) | |
| | | | 8b. Time of | 28c. Inju | | | | | |
| | 2 ☐ Accident Investigation | (Month, Day Your) | irijuty | | | | | | |
| | 3 Sulcide 6 Could not be determined | 28e. Placa of Injury - At hom | ne, term, stree | t, factory, offica | : | | | er or Rural R | oute Number, |
| į | | ounding, oto. (opcomy) | | | | , | ,, | | |
| | | alcian: To the best of my knowl- ner: On the basis of examinatio and manner stated. | edge, deeth o on and/or inves | ccurred at the tile stigation, in my c | me, date and placa, a opinion, daath occurr | and due to the c ed at the tima, d | ause(s) and ma late and placa, | anner as state and dua to the | d. a cause(s) |
| | 29b. Signature and title of cartifier | | | 29c. Licens | se number | 2 | 9d. Date signe | d (Month, Day | , Year) |
| - [| Med | (J) | | DU | 1948 | | Soot. | 3 19 | 97 |
| | | 1 - 1 | | 107 | 7170 | 0 | JUNI 9 | 0 11 | 1 1 |
| 3 | 30. Name and address of person who co | mpleted cause of deeth (Item 2 | 3a) (Type. Pri | int). | | | | | |
| 3 | 30. Name and address of person who co | mpleted cause of deeth (Item 2 | 23a) (Type, Pri | Lie Sy | eneral 1 | Hasnit | 0 | | |
| capal comparation to be compared by the capal breaking by the capal breaking by fullered b | | 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 17. Father's Neme (First, Middle, Last) 19a. Informant's Name/Reletionship (7) 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature Funaral Servica Licans 23a. Part 1. Enter the disease, or complahock, or heart tailure. List only of the disease or condition resulting in deeth) Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Part II. Other aignificant conditions conditions or injury that initiated events rasulting in death) Last 25. Was case reterred to medical examiner? 1 Yes 2 No 27. Manner of Deeth 1 Matural 5 Pending Investigation 3 Sulcide 6 Could not be determined 29a. Certifier (Check only one) 29a. Certifier Certifying Physical Cause Could not be determined 29a. Certifier Certifying Physical Examination Could not be determined 29a. Certifier Certifying Physical Examination Could not be determined 29a. Certifier Certifying Physical Examination Could not be determined 29a. Certifier Certifying Physical Examination Could not be determined 29a. Certifier Certifying Physical Examination Could not be determined 29a. Certifier Certifying Physical Examination Could not be determined 29a. Certifier Certifying Physical Examination Could not be determined 29a. Certifier Certifying Physical Examination Could not be determined 29a. Certifier Certifying Physical Examination Could not be determined 29a. Certifier Certifying Physical Examination Could not be determined 29a. Certifier Certifying Physical Examination Could not be determined 29a. Certifier Certifying Physical Examination Could not be determined 29a. Certifier Certifying Physical Examination Could not be determined 29a. Certifier Certifying Physical Examination Ce | 3 Widowed Divorced If Yes, Give' Year or Dates: 15. Decedent's Education (Specify only highest grade completed) | South Sout | Sequentially list conditions, if any, teeding to the disease, or complications that cause the first billion resulting in death) Last Sequentially list conditions, if any, teeding to the disease, or complications that cause on each line. Due to (or as a consequence of): Sequentially list conditions, if any, teeding to the disease, or complications that cause on each line. | Securities Sec | Yes Calk No Specify: 1 Yes 2 2 2 2 2 2 2 2 2 | Specify Spec | 101. Street and Number 102. Sec Code 109. Citizen of What Country 108. Street and Number 108. Sec |

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q 7

27437 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** VERA OLGA QUINN /Medical 4a, Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 900 Caton thCare Hea imore N/A If Under 24 Hrs. 5. Social Security Nur 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, 9. Birthplece (State or Foreign Country)
BALTO., MD **Funeral** 1□ M 💥 F Months Deys Hours Min 216-01-0451 79 20,1918 Director FEB Usuel Residence of Decedent 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No BALTIMORE CATONSVILLE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Counfry? 1214 WESTERLEE PLACE - 1-B 21228 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Baca - American Indian Bleck, White, etc. filed within 72 hours efter 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Widowed 4 □ Divorced WHITE Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 8TH GRADE TECHNICIAN WESTINGHOUSE permit. Peges 1 and 2 should be file.
Department of Health and Mental Hy
important: if item 27 is merked oths
any injury or other traumatic. 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be FREDERICK SIEBER ANNA MEYER 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) MICHAEL F. QUINN (SON) 2122 LORRAINE AVENUE - BALTIMORE, MD 21207 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2X Cremetion 3 ☐ Removel from Stete CARROLL CREMATION 9/5/97 HAMPSTEAD, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signetuu Funeral/Service Licansee HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart feilure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medicai Immediete Ceuse (Finel diseese or condition resulting in deeth) Examiner e consequence of) Examiner USLON Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieled events resulting in death) Lest and Due to (or es a consequence of): physician a s the buriel-Box 68760 Physician/Medical the Due to (or es e consequença of) Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No SaProbably 4 Unknown signed b þ 24b. Were autopsy findings evelleble prior fo completion of cause of deeth? page 2 should Completed 24e. Wes an autopsy performed? cete 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 450 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ CDOA Hospital or Attending Physical hours effer death. 28c. Injury et Work? 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 5 Pending Investigation 1 Naturel 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide Funerai 15 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end menner steted. Medical 29a. Certifier To the Hosp within 24 hor To the Fune completely fi 29b. Signeture end title of confiner 29d. Dete signed (Month, Day, Year) 29c. License number Septenher 3RD 1997 D050907 Slun nd endess of person who completed cause of deeth (Item 23e) (Type, Print) Bulhnone, MD Mehille Soull MD 900 (Month, Day, Yeer) 0 1997 32. Registrar's Signeture State who Durdson Registrar

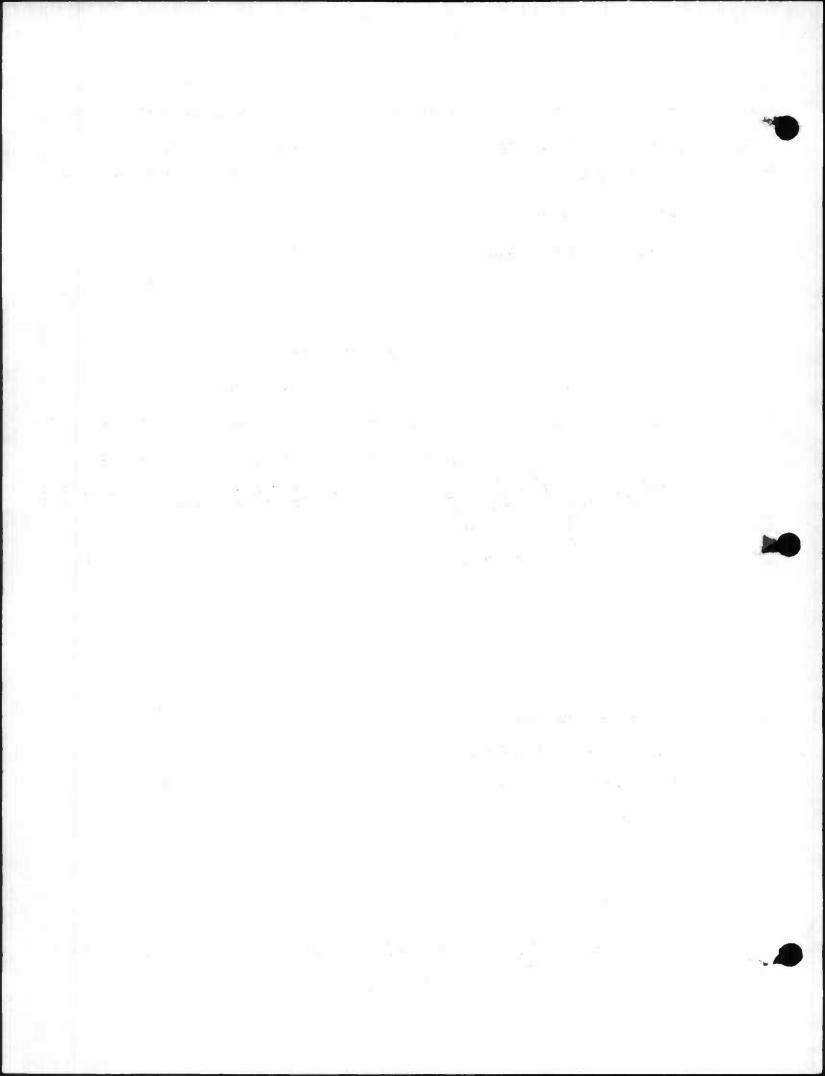


State of Maryland / Department of Health and Mental Hygiene Q7 271.20

| | | | | | C | ertifica | te of | Death | | Reg. No. | 1 4 | 1430 |
|--|-----------------|---|--|---|---------------------------------|------------------------------|---------------------------------------|---|--|---------------------------------------|--|---|
| Physicia | an | 1. Decedant's Nama (First, Mid | die, Last) | | | | | - 1 | 2. Data of D Month | Day Day | Year | 3. Tima of Death |
| _ /Medic | | Joyce | Ann | | ITE | QUEE | N | | Septem | ber 5 19 | | 4:00 A.M. |
| Examin | er | 4a. Facility Nama (If not institute | | | | | | 4b. City, Town, or | Location of Des | th 4c. Count | y of Death | |
| | | Franklin Squar 5. Social Security Number | | | | M Lind | er 1 Year | Rosedale | | Balt: | | |
| Funeral Director | | 212-32-8549 Usual Rasidance of Decedant | 6. Sex 1 □ M 2 € F | 7. Aga (In yrs 6 2 | Yrs. | Month | | | | 2/1935 | 9. Birthple Countr Mar | nce (State or Foreign y) y l a n d |
| r 28a-1 show | tor | 10a. Stata 10b. Coun | ty N/A | 10c. C | ity, Town or | Location CIMOR | E | | | | 100 | d. Inside City Limits Nas 2 □ No |
| th with the 23a or 28a | ai Director | 10e. Street and Number 2310 RUECKE | ERT AVENU | UE | | 10f. 2 | ip Coda | 1214 | | 10g. Citizan of | What Countr | y? |
| urs after dea hi', or itema examinar its | by Funerai | 11. Marital Status 1 Navar Married 2 Ma 3 X Widowed 4 Divorce | arried 1 ☐ Yes | cedent Evar In U forcas? 2 😭 No iiva Datas: | J,S. 1 | | edant of I ecify Cub 2\lefta No | Hispanic Origin? (S an, Maxicen, Puerl Specify: | Specify Yes or N to Rican, atc.) | 14. Rai Bla Specii | ce - Amarice ck, Whita, at y: B1 | |
| natural, | ted | 15. Dacede | ent's Educetion lest grade completed | n | 16a. De | cedant's Us | ual Occu | pation | rkina | 16b. Kind of B | usinass/Indu | ıstry |
| d within giene. | To Be Completed | Elementary/Secondary (0-12) | | (1-4or 5+) | | | | during most of world) | rking | BARC | | |
| be filed ntal Hygie of other event, tr | 3e C | 17. Fathar's Nama (First, Middle | e, Last) | | | | | 18. Mothar's Nar | ma (First, Middl | e, Maiden Surnar | n <i>e)</i> | |
| should be f nd Mental I marked of | To | Joseph Whi | te | | | | | Julia | a Whit | e | | |
| 2 shou and M Is mar aumat | | 19a. Informant's Name/Relation | | | | | | t and Number or Ru | | | | |
| and salth | | Charles Whi | te | | 231 | 10 Ru | ecke | ert Avei | nue, B | altimo | ce, Mi | D 21214 |
| Pages 1 and 2 should nent of Health and Men ant: If Item 27 is marke ury or other traumatic | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cramation 4 ☐ Donation 5 ☐ Other (| | State | Place of Discometery, of Crisco | rematory or | other pla | | Data Cem. | 20c. Location Owings | | m, State |
| permit. Page Department of Important: If any injury or once. | | 21 Signature of Funaral Sarvic | e Licenson | an o | + 4 | EROY | 0. | ass of Facility $DYETT$ $ERTY HE$ | S SON | FUNERAI AVE.,BA | HOM. | E, P.A. 21207 |
| Physician | | 23a. Cart 1 Criter the disease shock, or heart failure. Li | complications that only one causa on | ceused ha daa each li | | | | | | | | Approximata nterval Betwean Onsat and Daath |
| /Medicai Examiner | 4 | tmmediate Cause (Flnat diseasa or condition rasulting in death) | a Uros | epsis | | | | | | | 7 | days |
| | Je. | | | Dua to (| or as a cons | sequence o | n): | | | | | |
| icata be executed physician and s the burial-transit | Examiner | Sequentially list conditions, if any, leading to immadiate ceusa. Entar Underlying Causa (Disaasa or Injury | b | Dua to (| or as a cons | saquance of | j): | | | | | |
| in o a | Medical | that initiated avants rasulting in daath) Last | d | Dua to (| or as a cons | aquence of |): | | | | | |
| death ce | by Physician/ | Post II. Other clandfloods on die | | d==44 | | | | | 001 01 | | | |
| E 62 | hys | Part II. Other eignificant condit | | Jean DUL FOL FA | sulling in the | a undanying | ceusa gr | van in ran i. | | Yes 2 No | ontribute to t 3 ☐ Proba | the cause of death? ably 4 ☐ Unknown |
| a began | by F | Chronic Renal | Failure | | | | | | | 74 | | , Juliani |
| a should | Completed | Human Immunode | ficincy V | irus | | | | | 24a. Wa | s an autopsy formed? | avai | a autopsy findings labla prior to pletion of ceuse eath? |
| ysician: The last is certificate has director, paga 2 | E | Acute Cerebrov | ascular A | ccident | | | | | 1 🗆 | Yas 2 No | 10 | Yas 2 No |
| an: rtifica stor, I | Be | 25. Was cesa rafarred to medic | | 001100110 | | | | 26. Place of Dea | ath (Check only | one) | | |
| Affer this funeral di | 2 | axaminar? 1 Yes 2 No 27. Mannar of Death 1 Natural 5 Pend | 28a. Data | | ER/Outpat 28b. Time Injur | of | 28c. Inju Wo | 4 U Nursing F | | sidence 6 Ott | | |
| To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune | Certification: | 3 ☐ Suicide 6 ☐ Could | not be 28a. Plac | e of Injury - At h ling, atc. (Speci | | | | | | (Street and Numbown, State) | ber or Rural i | Route Number, |
| To the Hospital within 24 hours To the Funeral completaly filled | edical | 29a, Cartifiar (Check only one) Certify Certify Check only | ing Physician: To the t Examinar: On the b and mai | a best of my kno basis of axamine mer stated. | owledga, da ation and/or | ath occurre Invastigation | d at tha ti | ma, data and place opinion, daath occu | e, and due to the arred at the time | a causa(s) and m , data and place, | anner as state | ted. ha cause(s) |
| To the comp | Σ | 29b. Signature and title of certifi | er _1/ | / | . 4 | 2 | 9c. Licans | sa number | | 29d. Data signe | ed (Month, Da | ay, Year) |
| 77 | | 30. Name and address of person | n who completed cau | sa of daath (tte | m 23a) (Typ | De, Print) | 1) | 40819 | 7 | Septemb | er5, | 1997 |
| */ | | Dr. Marcus Zam | 11 | | , , , , , | | ive | Baltimor | e,Md. | 21237 | | |
| Stat Registra | e | 31. Date filed (Month Pay Yea | fillia | Radistrar's Sign | Mandel | Ne. | | | | | | |

DHMH 16 Ray 6/95

Registrar



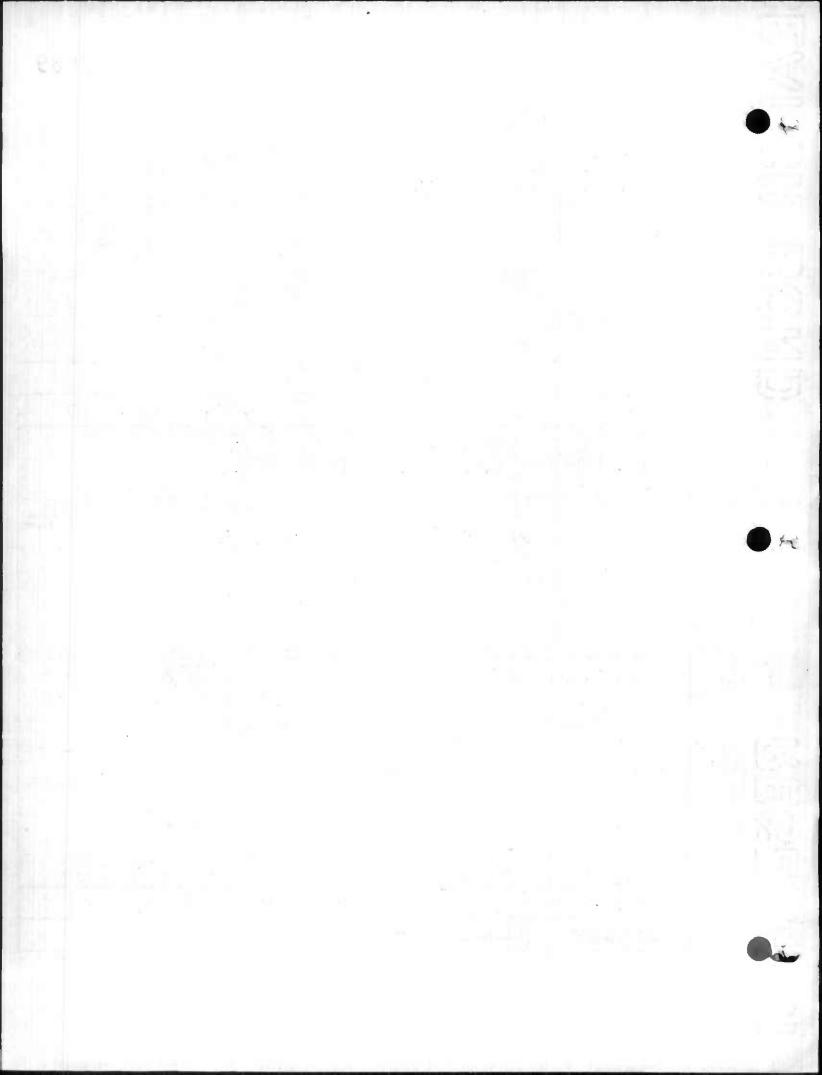
1 - STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | HEGISTRAN | | OLITIII | ICATE | OF DEATH | | REG. NO. | | | |
|---------------|---|--|-------------------------|--|--|------------------|---------------------------------------|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | Rosariu | 5 | | | 2. DATE OF MONTH | F DEATH DAY | 3. TIME OF DEA | | |
| | 4. SOCIAL SECURITY NUMBER | | (In yrs. last birthday) | IF UNDER 1 Y | EAR IF UNDER 24 HRS | 5. 7. DATE OF | BIRTH | 8. BIRTHPLACE (State or F | | |
| | 216-20-8182 | t M 2XXF 8 | | | AYS HOURS MIN | Jan. | 23, 1908 | Maryland | | |
| | 9e. FACILITY NAME (If not institution, give s | | | 9b. CITY, TO | OWN OR LOCATION OF | | | INTY OF DEATH | | |
| SH | Genesis- Caton | Manor Nursin | q Ctr. | Balt | imore Cit | V | | N/A | | |
| 5 | RESIDENCE OF DECEDENT 108. STATE 106. COUNTY 10C. CITY, TOWN OR LOCATION 164. INSIDE CIT | | | | | | | | | |
| DIRECTOR | Maryland N/A | * | | | re City (| Lakola | nd) | tod. INSIDE CITY | | |
| | 100. STREET AND NUMBER | | Da | i c illoi | 101, ZIP CODE | Lakera | | IZEN OF WHAT COUNTRY? | | |
| RA | 2502 Arbuton | Avenue | | | 21230 |) | tog. G1 | USA | | |
| FUNERAL | tt. MARITAL STATUS | 12. WAS DECEDENT EVER I | | 13. WA | S DECENDENT OF HIS | | (Specify Yea or No- | 14. RACE — American Indi | | |
| ВУ | t Never Married 2 Married 3 Wildowed 4 Divorced | FORCES? t YES | | If y | os, specify Cuban, Max YES 2 X NO Spe | dcan, Puarto Ric | an, etc.) | Specify: White, etc. | | |
| | t5. DECEDENT'S EOU (Specify only highest grade | ICATION completed) | tea. DECEDENT'S | work done duri | JPATION ing most of working | 16b. K | IND OF BUSINESS/IN | DUSTRY | | |
| H | Elementary/Secondary (0-12) | Callege (1-4 or 5+) | Homemak | se retired.) | | Ho | usowife a | nd Mother | | |
| COMPLET | 17. FATHER'S NAME (First, Middle, Last) | <u> </u> | Homemak | C1 | | | | na mother | | |
| | T. FATHER'S NAME (PISt, MIGGIN, LIST) | Sw | eet | te. Mother's Name (First, Middle, Meiden Surmerne) Sadie Yeager | | | | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | | Sadie reager nd Number or Rural Route Number, City or Town, State, Zip, Code) | | | | | | |
| 5 | Mr. Karl Rosorius | (Husband) | 2502 | Arbut | on Ave., | Baltim | ore, Mary | land 21230 | | |
| | 20a, METHOD OF DISPOSITION | | b. PLACE AND DATE | | | DATE | 20c. LOCATION | City or Town, Stata | | |
| | t X Burial 2 Cremation 3 Rem | Ioval from Stata Cer | L'oudon' P | ark Ce | emetery 9 | 0/6/97 | Baltimo | re, Maryland | | |
| | 21. SIO ATURE OF FUNERAL SERVICE LIC | CENSEE Kevin E | . Ecker | 22. NA M.O.C | ME AND ADDRESS OF | FACILITY | unonal Ho | me of Brook | | |
| | 1/6 | | | 237 | 7 E Datas | MITAK F | uneral no | ., Md. 2122! | | |
| | 23. PART I. Enter the diseases, or | complications that cause | d the death. Do | | | | | | | |
| | iMMEDIATE CAUSE (Final disease or condition resulting in death) | A Cute | Cerel | rova | sculor | Ae | reiden | Interval B Onset and | | |
| z | | Med Co | evelso 0 | Porte | lor H | ead | ent | 1700 | | |
| CERTIFICATION | Sequentially list conditiona, if any, leading to immediate | The second secon | A CONSEQUENCE O | | | | | | | |
| CA | cause. Entar UNDERLYING CAUSE (Disease or Injury | c | | | | | | | | |
| HE. | that initiated events resulting in death) LAST | DUE TO (OR AS | A CONSEQUENCE O | F): | | | | | | |
| CER | | d | | | | | | | | |
| | PART if. Other aignificant condition | na contributing to death i | but not reaulting | in tha unda | riying causa given | in Part I. 2 | 4s. WAS AN AUTOPSY PERFORMED? | | | |
| EDICAL | Uros your | | | | | | YES 2 NO | AMILABLE PRIOR COMPLETION OF OF DEATH? | | |
| ME | | | | | | | | 1 - YES 2 0 | | |
| | | | | | | | | | | |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | OTHER: | 26. PLACE OF DEATH | (Check only one) | | | | |
| PHYSICIAN: | t YES 2 NO | 1 Inpatient 2 ER/Out | | 4 Nursin | Home 5 Residen | _ | | | | |
| | 27. MANNER OF DEATH 1 Natural 5 Pending | (Month, Day, Year) | 26b. TIN | URY | c. INJURY AT WORK? | 28d. OESC | RIBE HOW INJURY OC | CURED | | |
| BY | 2 Accident Investigation | 28e. PLACE OF INJURY | V - At home for | | YES 2 NO | 204 1000 | ION /Physical and All | a Demi Commit | | |
| ED | 3 Suicide a Could not be 4 Homicide detarmined | building, etc. (Spe | ecify) | error, rectory | , orne | City or | ION (Street and Numbe Town, State) | r or Rural Route Number, | | |
| LEI | 29a. CERTIFIER . M. CERTIFYING BUYE | MOVANI, To she had a second | | | | | | | | |
| COMPLETE | 1 | ER: On the best of my know ER: On the besis of examination | | | | | | | | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIE | | - A | , my opin | | | | | | |
| BE | (Dynige M) | Attendo | w Joo | ter | 29c. LICENSE I | 168 L | 29d. DAT | FE SIGNED (Month, Day, Year) | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WI | 10 COMPLETED CAUSE OF DE | EATH (ITEM 27) (Type | , Print) | 100 | .00, | | 7 77 | | |
| | CN. (40 IAP-M. | A P | RITE | 410 1 | 2 -1 36 | DACAN | enlA M | 1 11120 | | |
| | Coloration | 10.01 | | V1 012- V | sul p | MON | 1 | 0 21122 | | |
| | 31. DATE FILED (Month, Day, Year) SEP 1 0 1997 | SI. REGISTRAN'S SIGN | | 01 015- 0 | owi p | rejon or | 1 | 0 21122 | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020



97-5097-510 B.K.S TODD DUANE RONEY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97

27440

| | | | | | Certificate of | f Death | Rec | . No. | | ~ / ~ ~ 0 |
|------------|--|---------------|--|--|--|--|---|------------------------------|-------------------------|---|
| | Dhualai | | 1. Decedent's Name (First, Middle, Las | st) | | | 2. Date of Death Month | | | 3. Time of Deeth |
| Л | Physici /Medi | | | Todd Duan | e Roney | | ~ | 7, 199 | 7 | 0949 AM |
| S | Examir | | 4a. Facility Name (If not Institution, give | e street end number) | | 4b. City, Town, or I | ocation of Death | 4c. County | of Death | |
| 100 | | | 1900BLK. HUNTON | | | BALTIMOR | Œ | | | |
| | Funeral Director | | 313-32-2389 | MM OFF | s. last birthday) If Under 1 Yea Months Dey | | 8. Date of Birth (Month, Day, 1) July 10 | | 9. Birthpiec Country | ce (Stete or Foreign) In |
| | 72 hours after death with the Merylend netural; or items 23s or 28s-1 show death Enaminer much notified. | | Usual Residence of Decedent 10a. State 10b. County | 10c, C | City, Town or Location | | | | 10d. | . Inside City Limits |
| | | | Md N/A | | | | | 1 Ves 2 No | | |
| | the 28s | Director | 10e. Street and Number | D | altimore | | 100 | c. Citizen ot | What Country | 7 |
| | 3a o | | 2320 Sulgrave A | venue | 212 | 09 | | US | | |
| | death | Funeral | 11. Marital Status | 12. Was Decedent Ever In | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- | | | | |
| 020 | 72 hours after dea "natural", or items | by | 1 Never Merried 2X Married 3 Widowed 4 Divorced | Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☑ No | | erto Rican, etc.) Black, \ Specify: | | | :. :k |
| 5-0 | 72 ho | ted | 15. Decedent's Ed (Specify only highest gra | ucation | 16a. Decedent's Usual Occi (Give kind of work don | upation | tina 16 | 6b, Kind of B | usiness/Indus | itry |
| 21215-0020 | within ene. then | Completed | Elementary/Secondary (0-12) 12th grade | College (1-4or 5+) 2 years | life. DO NOT use retir Substitute | red) | King | Scho | 01 | |
| | be filed that Hygind other event, is | Bec | 17. Father's Name (First, Middle, Last) | 2 Jeans | | 18. Mother's Nan | ne (First, Middle, Ma | aiden Suman | ne) | |
| aryland | should be ind Mental marked of umatic evi | To | Preston H. Rone | у | | Gwendo | lyn Hurtt | | | |
| and a | 2 sho end 8 | ľ | 19a. Informant's Name/Relationship (7 | Type, Print) | 19b. Mailing Address (Street | et end Number or Ru | ral Route Number, | | | ode) |
| Z, | 1 and Health em 27 | | Preston & Gwendoly | | | ave Avenue | Balto, | Md 21 | 209 | |
| ltimore, | Peges 1 nent of Hi nft: If iten | | 20a. Method of Disposition 1)☐(Burial 2 ☐ Cremation 3 ☐ | | Place of Disposition (Neme of cemetery, crematory or other pi | /ace) | Date 20 | c. Location | City or Town | , Stete |
| Ē | ment ment tant: If jury o | | 4 Donation 5 Other (Specify |) D | ulaney Valley | Cemetery 9 | 9-10-97 T | imoniu | m, Md | |
| Ba | permit. Peges 1 a Department of Hee Important: if item any Injury or othe | | 21. Signeture of Funeral Servica Licen | See O | 22. Name end Add | | | | | 2121 |
| _ | 00200 | | - Gabriel (| i COOK | March F, | | ann Wabasi | n Aven | ue Bal | |
| | | | 23a. Part1. Enter the disease, or comp shock, or heert feilure. List only | plications that caused the decone cause on each line. | ath. Do not enter the mode of dy | ying, such as cardiad | or respiratory arres | it, | Ar | pproximate terval Between |
| | Physiclan | | | | 1 | 6 11 | ^ | | O | nset and Deeth |
| | /Medical Examiner | | Immediate Cause (Finel disease or condition resulting in death) | a. Gunsho | + Wound o | + Hea | .2 | | 1 | |
| | | e | , | Due to | (or es a consequenca of): | | | | | |
| | heit | Examiner | • | b. — | | | | | - | |
| - | certificate be executed ding physician end ise as the buriel-transit | Exal | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to | (or as a consequence of): | | | | | |
| 68760, | sicial | | Cause (Disease or Injury that Initiated events | C. | | | | | | |
| 89 | ficate p phy as the | edicai | resulting in deeth) Last | Due to (| or as e consequence of): | | | | | |
| XO | | M/u | | d | | | | | | |
| m | deeth deeth ee etten | sicia | Part II. Other significant conditions co | entributing to death but not re | sulting in the underlying cause o | iven in Part I | 23h. Did toh | acco usa co | ntribute to th | ne causs of death? |
| P.0 | that the deeth red by the etter deteched for t | by Physician | • | ~ | outling in the arrival groups of | | 1 Tyse | -1 | 3 Probab | |
| ecords, | R | Cômpleted b | | | | | 24a. Was an performe | autopsy ed? | evaila | autopsy findings able prior to eletion of cause eth? |
| Œ) | | ±0. | | | | | 1 Xyes | 2□No | 1/24 | es 2 No |
| Viita | ysician: s certifica director, | Be (| 25. Was case referred to medical | | | 26. Plece of Dea | th (Check only one) |) | | |
| ot v | S 00 0 | 2 | examiner? | Hospital: 1 ☐ Inpatient 2 [| □ ER/Outpatient 3□ DOA O | ther: 4 Nursing H | ome 5 Residen | ce XXOth | er (Specify) | ROADWAY |
| | ilng Ph J. After th funeral | on: | 27. Menner of Death 1 □ Natural 5 □ Pending | 28a. Date of Injury Month Day Year) | 28b. Time of 28c. Inj Funjury M | ury at ork? | 28d. Describe how | Injury occur | | |
| Sio | Attending or death. ector: After by the fune | cat | 2 Accident investigation | 9-7-97 | 920 AM 10 | Yes 2010 | subject | 23 . 467 | | |
| Division | or Attending I after death. Director: After I in by the funer | ertification: | 3 Suicide 6 Could not be determined | 28e. Placa of Injury - At building, etc. (Spec | | 9 | 28f. Location (Stre City or Town, | et and Numb Stete) 1911 | OBIL H. | oute Number. |
| | urs a urs a real D | O | | | park | | Baltinur | e hd | | |
| | Hospital 24 hours Funeral stely filled | edical | 29a. Certifier (Check only one) 1 Certifying Phy MMedical Exam | Iner: On the basis of examin | owledge, deeth occurred at the atton and/or investigation, in my | time, date and pieca opinion, death occur | red et the time, dat | se(s) and me e and placa, | and due to the | e ceuse(s) |
| | To the Hospital or At vithin 24 hours after of To the Funeral Direct completely filled in by | Med | 29b. Signeture and title of certifier | and menner stated. | | nse number | | | d (Month, Da | |
| | E 30 1 1/2 | | - | | | | 200 | B.10 | - t | // |

O.C.M.E

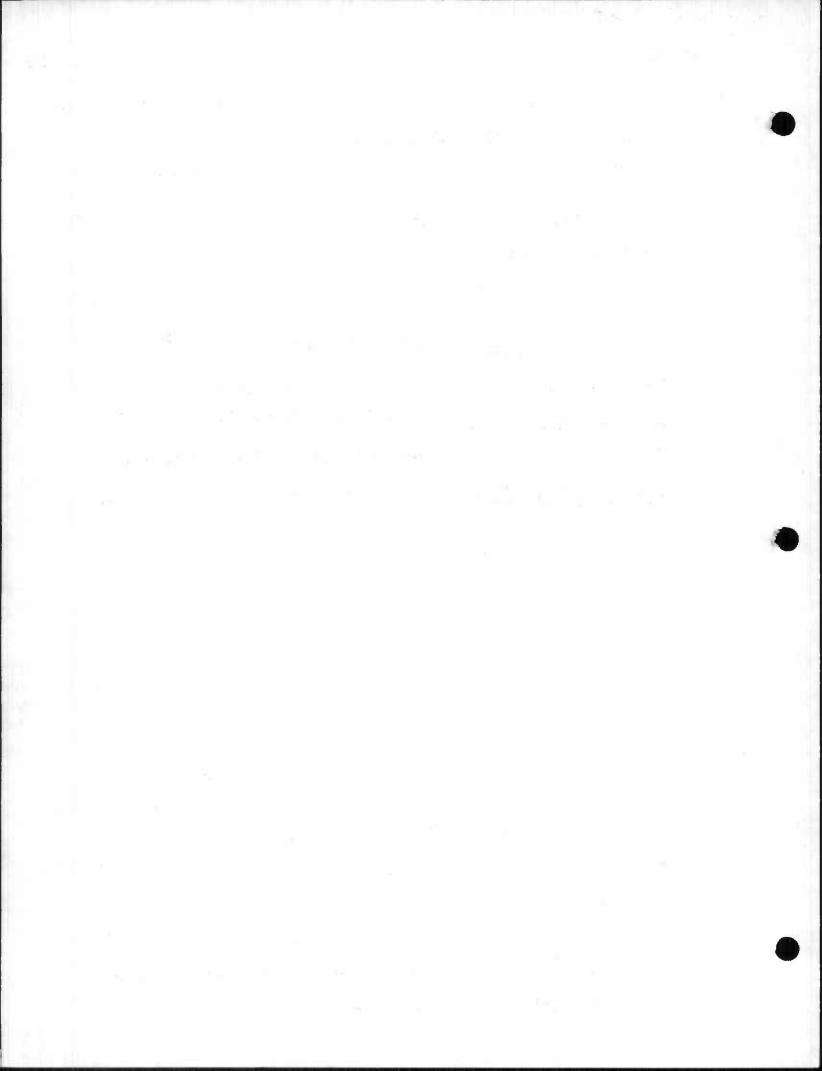
completed cause of death (Item 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

SEPT. 8, 1997

State Registrar

DHMH 16 Rsv 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Francis Reiser /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Saltimore Hospi if Undar 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplece (Stete or Foreign Country) **Funeral** 10 M 2□ F Yrs. Director 101-20-1458 New Usuel Residence of Decedent death with the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 la marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at 1 Yes 2 □ No Director N.Y. Broome Endicott 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 307 East Main St.

Marital Status

1 Never Married 2 Married

1 Never Married 2 Married

1 Never Married 2 Married

1 Never Married 2 Married

1 Never Married 2 Married

1 Never Married 2 Married

1 Never Married 2 No If Yes, Give Year or Dates: Korchy Funeral USA 1376 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or than any injury or other transment. Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify. þ White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Tool & die College (1-4or 5+) 12 0 Machinist Machinery 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumama) Frank Reiser Margaret Burke 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) June Kelly (Daughter) 1731 Benson Ave. Brooklyn 11214 N.Y. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1⊠ Burlal 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Pinelawn Cemetery 9-11-97 Pinelawn N.Y. 22. Name and Address of Facility
Della Noce & Sons Funeral Home 21. Signature of Funeral Service Liganian 322 S. High St. Baltiiore 21202 Md. o, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, List only one cause on each line. Approximate Interval Betwaan Onsat and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medicai Examiner Examiner physician and the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last acustra Box 68760, Physiclan/Medical USB as cardiae arrest signed by the atte Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yas 2 No 1 □ Yes 2 □ No 25. Wes case referred to medical examiner? 26. Placa of Daath (Check only ona) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? Certification: 1 Netural 5 Pending investigation death. 1 ∏Yes 2 ∏No 2 Accident or Attand after death Director: / 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homleide To the Hospital or within 24 hours aft To the Funeral Discompletely filled in edical 29a. Certifier 1 🗓 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the ceuse(s) end manner es steted. (Check only one) 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signature and title of certifiar 29c. License number 29d. Date signed (Month, Day, Year) AS 240 2321-089854 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Baltmore 2401 W. Behader and 31. Dete filed (Month, Dey, Yeer) State Registrar

DHMH 16 Rev 6/95

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WRC 97-5042-027 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. JON L. State of Maryland / Department of Health and Mental Hygiene REEVES Items:23a part I,27 per MEO G-751 9/30/97 dh Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death 04,1997 Year **Physician** JON L. REEVES SEPT. 11:29 AM. /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death HOWARD COUNTY GENERAL HOSPITAL COLUMBIA HOWARD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplece (State or Foreign 1XM 2□ F 48 Yrs. Director 382-50-8968 SEP. 18, 1948 MICHIGAN Usuai Residenca of Deceder the Marylend 10a, State 10b. County 10c. City, Town or Location 10d. inside City Limits 智 notified 1 ☐ Yes 2 No Director 28a-f CA LOS ANGELES VALENCIA 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? me 23a or 91355 24918 AVENIDA BALITA U.S.A. Funeral Rems ; 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ŽŽŽNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. the Medical Examiner filed within 72 hours after 1 ☐ Never Married 2 ▼ Married 21215-0020 6 1 ☐ Yes XXNo Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: natural Completed 15. Decedent's Education 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grede completed) I Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 12th TRUCK DRIVER MOTION PICTURE INDUSTRY Baltimore. Maryland 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental I 90 traumetic THOMAS J. REEVES RUTH ELIZABETH MOHR 19e. Informant's Name/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) if item 27 VIKKI L. WILLIAMS (WIFE) 24918 AVENIDA BALITA VALENCIA CALIFORNIA 91355 other Pages 1 20a. Method of Disposition 20b. Placa of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State 6 1 Burial 2 Cremation 3 Removal from State Dependent of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) CARROLL CREMATION SERVICE 9/8/97 HAMPSTEAD MARYLAND 21. Signature of Funeral Service Licensee 22. Name end Address of Facili WITZKE FUNERAL HOME, INC. OF COLUMBIA tras m 5555 TWIN KNOLLS ROAD COLUMBIA MARYLAND 21045 23e. Pert1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician /Medical Immediete Ceuse (Final ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in death) Examiner Due to (or es e consequenca of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The lew requires that the death certificate be exec 68760 Physician/Medical the Due to (or as a consequenca of): 98 Box (Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown yd bengis 1 Yes 2 No Records, þ 99 24b. Were autopsy findings evailable prior to Completed 24a. Was en eutopsy performed? page 2 should completion of cause of death? 1 Yes 2 No 1 Yes 2□ No tertificate Vita Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No **2O**ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred XX Naturel 5 Pending investigation Injury 1 TYes 2 □ No 2 Accident 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) afte 4 Homicide Hospital To the Hospital within 24 hours a To the Funeral C 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end pleca, end due to the cause(s) and manner stated. 29b. Signature and title of cartifie 29c. License number 29d. Date signed (Month, Dey, Year) O.C.M.E. SEPT. 05, 1997

State Registrar MALYDUM

31. Date filed (Manth Day Year)

32/Registrarie Signature
Juna Variation—Randelle

ed cause of death (Item 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

SEP 1 (1997)

SEP 1 (1997)

and eddless of person who com

h 100

97-5087-510 B.K.S DORETHA SWINTON

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

4e. Fecility Name (If not institution, give street end number)

1016 NORTH ROSEDALE STREET

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of M

If Under 1 Year

Swinton

7. Age (In yrs. lest birthdey)

| aryland / | Department of Health and | Mental | Hygien |
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| | Certificate of Death | | Reg No |

2. Date of Deeth

SEPT.

4b. City, Town, or Location of Deeth

BALTIMORE

| Physician |
|-----------|
| /Medical |
| Examiner |
| |

Funeral Director

If Under 24 Hrs. Hours Min. Months Deys 1□ M 2\ F 246-09-1817 Yrs 8-25-1920 Usual Residence of Decedent the Marviand 10a State 10b. County 10c. City, Town or Location 28a-f show must be notified at Md Director N/A Baltimore 10e. Street and Number 10f. Zip Code ŏ items 23a 1016 N. Rosedale Street 21216 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 X No Specify þ 3X Widowed 4 □ Divorced Completed the Medical 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) N/A^{College (1-4or 5+)} permit. Pages 1 and 2 should be filed within Department of Health and Mantal Hygiane. Important: If item 27 is marked other than any Injury or other traumatic event, the Magnetic Pages. Elementary/Secondary (0-1 12th grade Dietitian 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Unknown Edna Battle 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Joseph S. Battle - Nephew 1812 Effingham Street Portsmouth, Va 23704 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) Metro Crematory 9-10-97 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility March F/H West la Warne 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one ceuse on each line. 4300 Wabash Avenue Baltimore, Md 21215 **Physician** Immediate Cause (Final disease or condition resulting in death) . ATHEROCCUENTIC CAMPIONASCULAR SUSTEM Examiner Due to (or es e consequenca of): Examiner be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest and tran Due to (or es e consequence of) physician Box 68760, Physician/Medical the Due to (or as a consequence of) ettanding for usa as D.0 Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 8 Ē Be Completed by 24a. Was an autopsy performed? Yes Division of Vital Attending Physician: 25. Was case referred to medical examiner? certifi 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home XXResidence 6 Other (Specify) Certification: To Yes 2□ No 27. Menner of Deeth 1 Netural 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Aftar 5 Pending investigation To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: All completely filled in by the fu death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide edical 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end placa, end due to the cause(s) and manner es stated.

**Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature end title of cartifier 29c. License number SEPT. 7, 1997 O.C.M.E ieted cause of death (Item 23e) (Type, Print) KORSU 16 111 Penn Street, Baltimore, Maryland 21201

32, Registrar's Signature

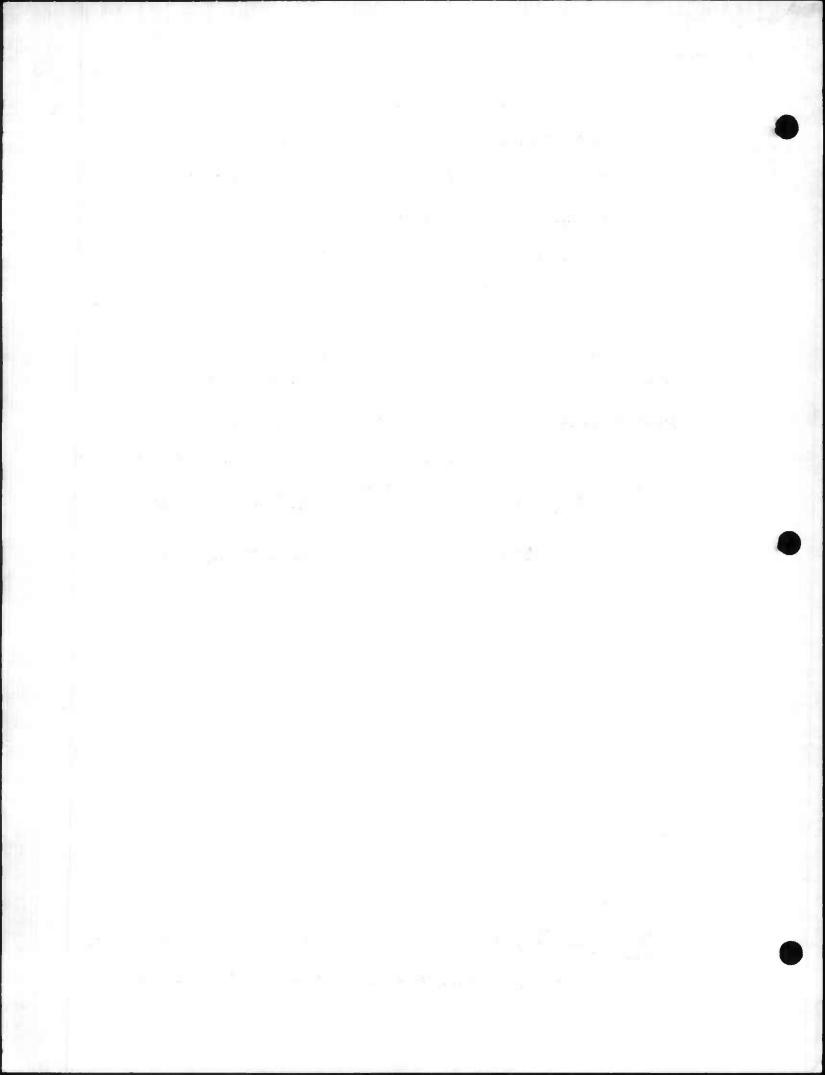
wha Davidson Randelle

Doretha

Reg. No. 3. Time of Death 1997 10:40 AM 4c. County of Death 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) N.C. 10d. Inside City Limits 1 Yes 2 □ No 10g. Citizen of What Country? SA U 14. Rece - American Indian, Black, White, etc. Specify: **Black** 16b. Kind of Business/Industry School 20c. Location - City or Town, Stete Catonsville, Md Approximate Interval Between Onset and Death 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings evelieble prior to completion of cause of death? 1 Yes 2 No 2 No Location (Street and Number or Rural Route Number, City or Town, Stete) 29d. Dete signed (Month, Dey, Year)

State

1 0 1997



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. MT. State of Maryland / Department of Health and Mental Hygiene Items:23a part I,27,28a-f per MEO G-751 9/16/97 dh Certificate of Death 1. Decedant's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Stephen Μ. Scott SEPTEMBER 07 1997 10:34 AM /Medical 4a. Facility Name (If not institution, give straat and number) 4b. City, Town, or Location of Death 4c. County of Death 833 POPULAR GROVE STREET BALTIMORE 5. Social Security Number If Undar 1 Year If Undar 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** 8. Data of Birth (Month, Day, Year) Days 1 X X 2 F Months Hours 217-96-8944 Yrs 30 Director 07-10-67 Md. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Insida City Limits Md. NA Baltimore 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 5 muntbe 1233 North Augusta Avenue 21229 23a USA death Funerai natural', or items Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1√ Never Married 2 Married 1 Yes 2 No Specify: Black 21215-0020 1 ☐ Yes 2 XNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) E C 10th Grade other NA Laborer Hauwald Bakery altimore, Maryland nt: If hem 27 is marked way yor other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumama) Be Pages 1 and 2 should be Maxwell Tarbert III Barbara Scott 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 21229 Scott 1233 N. Augusta Avenue Baltimore, Maryland Barbara 20a. Method of Disposition 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nuriai 2 ☐ Cramation 3 ☐ Removal from State Department of Important: If any Injury or 5 Other (Specify) National Mem. PK. Cem 09-11-97 Laurel, Md. 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue Do not enter the mode of dying, such as cerdiac or respiratory arrest, Interval Between Physician /Medical Onsat and Daath Immediate Cause (Finai ACUTE ETHANOL AND NARCOTIC INTOXICATION disease or condition resulting in death) Examiner Due to (or as a consequence of) Jer be executed Examir Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or es a consequence of): 68760 Physician/Medical certificete the Due to (or as a consequence of) Box at the deeth Part Ii. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. o 23b. Did tobacco use contribute to the cause of death? the Ad be 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 2 Unknown 0 þ Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy complation of cause of death? Yes 2 No Ves 2□ No Vital Physician: Be 25. Was cese referred to medicai 26. Piaca of Death (Check only one) examiner?
Yes 2 No Other: 4 Nursing Homa 5 Residence 6 NOther (Specific CENE) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 of Certification: 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred A Division Attending investigation 1 □ Naturai death. 1 ☐ Yes 2XXNo after death Director: / 2 Accident unknown found:10:00 found 9/7/97 6 XXCould not be determined 3 Suicide 28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete): 833 Poplar Grove St. in by 4 Homleide To the Hospital of within 24 hours af To the Funeral Discompletely filled found in house Baltimore, Maryland edical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. (Check only one) 29b. Signatura and title of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year) O.C.M.E. SE PTEMBER 08,1997 WEND 30. Name and address of person tho completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Dey, Yeer)
SEP 1 0 1997

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hute no 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature he Davidson

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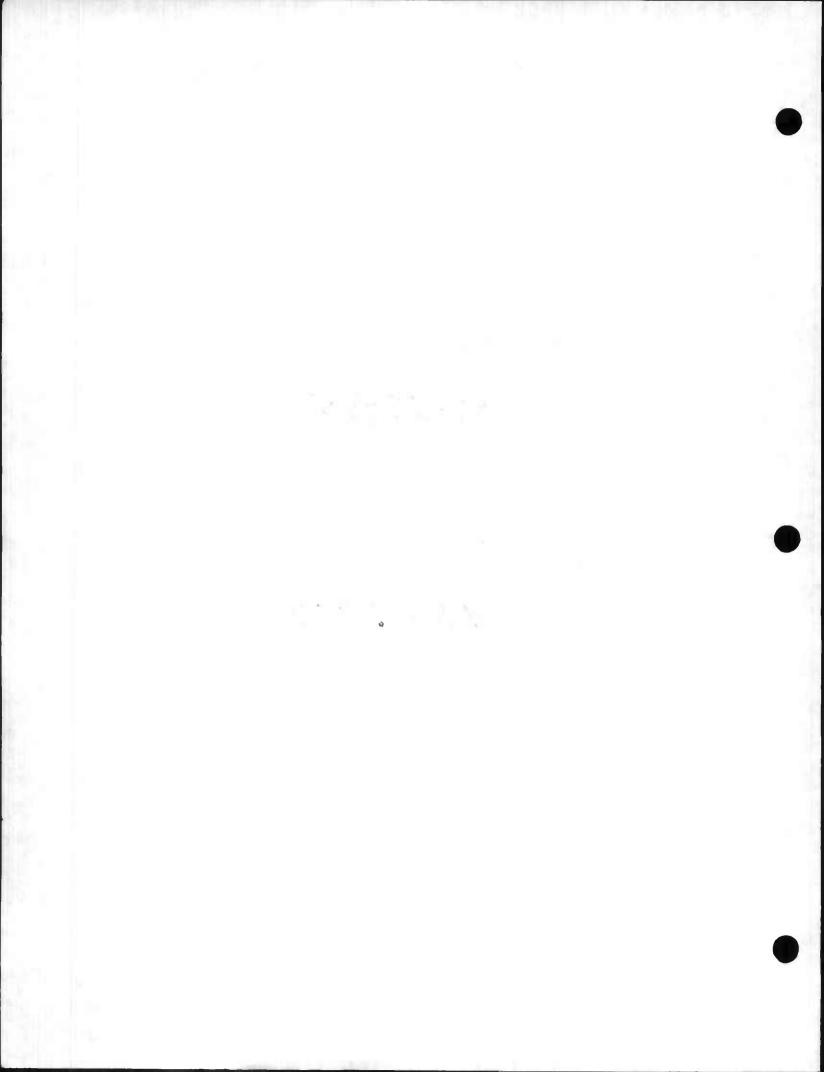
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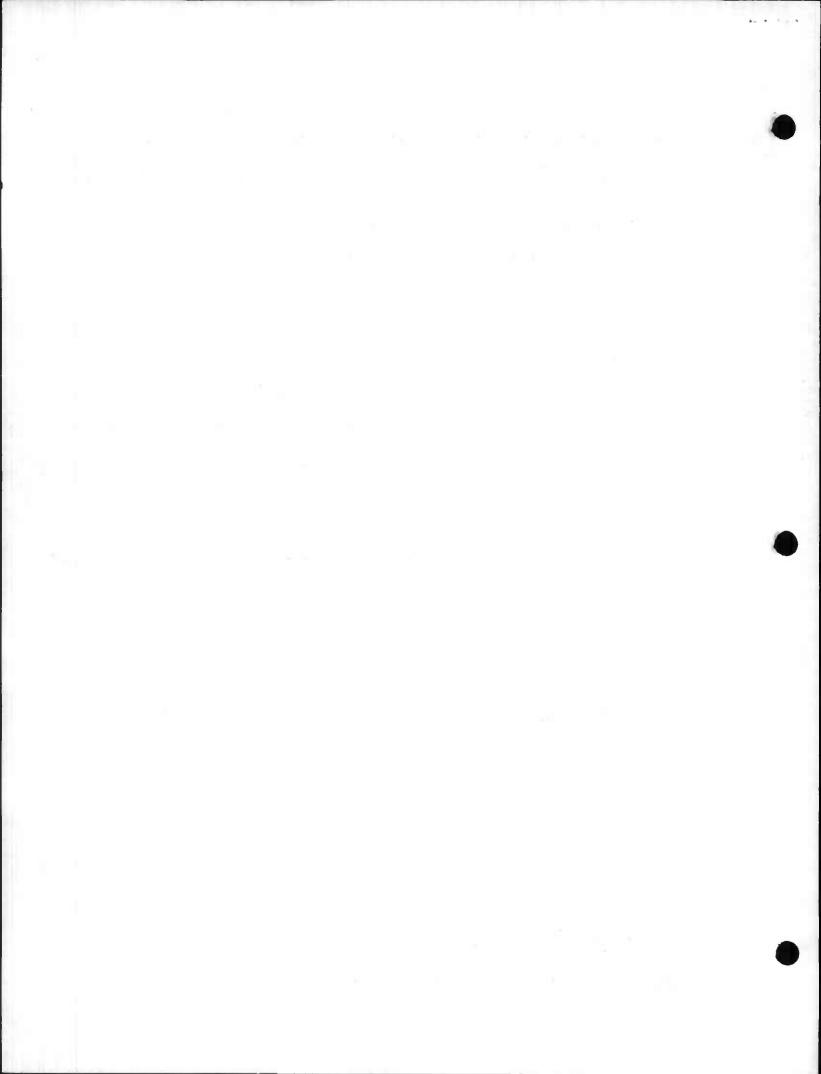
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97-27002



State of Maryland / Department of Health and Mental Hygiene 0.7

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| | /Medi | | helan J. Ju | bock | | | SEPTEM | | 1997 4:40p |
| | Exami | ner | 4e. Fecility Name (If not institution, give | | | 4b. City, Town, or I | ocation of Death | 4c. County of | |
| 1 | | | GREATER BALTIM | | | TOWSON | | BALTI | |
| | Funeral Director | | 5. Social Security Number 6. Security Number 910 - 92 - 9095 | MIN OUT | Yrs. If Under 1 Yee Months Dey | | 8. Date of Birth (Month, Dey.) | 1965 | 9. Birthplace (State or Foreign Country) Maryland |
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| 21215-0020 | ours afte rail, or it Examin | by | 1 Married 2 Married 3 Widowed 4 Divorced | 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | 1 □ Yes 2 N | | | | White |
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| 12 | her th | ပိ | 17. Father's Name (First, Middle, Last) | | tock clei | 7 | ne (First, Middle, Ma | aldon Cumoma | 1 |
| Maryland | ed by e | Be C | GOBACO I SI | Jacob | | 1) ANIR | I MIGGIO, IMI | in Ali | 10 |
| 2 | My My Mark | 5 | 19a. Informant's Name/Relationship (7 | vpe. Print) 19t | . Mailing Address (Stree | et end Number or Ru | rel Route Number | City or Town S | (U Table Zin Code) |
| ž | od 22 27 ts r frau | | Papis Sulvay | Q. | 009 Vilho | ida Pd | PODDII LI | 201 N | 11 2123/2 |
| re, | A Han | | 20e. Method of Disposition | o o m o to | f Disposition (Neme of ry, cremetory or other p | local . | Date 20 | Oc. Location - C | City or Town, State |
| altimore, | Page nert of ny or | | 1 Surial 2 □ Cremetion 3 □ 4 □ Donation 5 □ Other (Specify | Hemoval from State | my Com | depil | Jept 4 1 | hopvill | lo Mapulano |
| affi | mit partition in a second | | 21. Signature of Funeral Service Licens | 500 | 22. Name and Add | ress of Facility | 11.48 CK | 10000 | & MOUNDAIN |
| 8 | 907.88 | | * Noisda | 420000 | 00M H | inford K | od Ral | Lynna | Mal 212311 |
| | | | 23a. Pert1. Enter the disease, or comp shock, or heert failure. List only | lications that caused the death. Do | not enter the mode of d | ying, such es cerdiad | or respiretory erres | HIIII | Approximate |
| - | Physician | | shock, or neert failure. Elst only c | one cause on each line. | , , | 1 | | | Interval Between Onset and Deeth |
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| 1 | Examiner | | resulting in deeth) | e. Due to (or as e | consequence of): | .,,, | | | July |
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| P.0 | uires that the death cer signed by the attendir IId be detached for use | by Physician/ | Part II. Other significant conditions co | ritributing to death but not resulting if | n the underlying cause (| given in Pert I. | 1 T Yes | L/ | ribute to the cause of death: 3 ☐ Probably 4 ☐ Unknow |
| (Å | signed I | y P | paimon | as molling | 7 | | | 1 | on robusty 4 onknow |
| cords, | been sign | Completed b | | 0 | | | 24a. Was en performe | | 24b. Were eutopsy findings available prior to completion of cause of death? |
| 4 | 80.00 | шо | | | | | 1 ☐ Yes | 2 No | 1 ☐ Yes 2 ☐ No |
| 鱼, | for p | Be C | 25. Was case referred to medical | | | 26. Place of Dea | ith (Check only one) | | 12.100 22.10 |
| > | ya dana director | To E | examiner? | Hospital: 1 Inpatient 2 FVO | utpetient 3 DOA | Whor | ome 5 ☐ Residen | | (Specify) |
| n of | ding Phys h. After this funeral di | | 27. Menner of Deeth 1 ☑ Netural 5 ☐ Pending | | Time of 28c. Inj | ury et ork? | 28d. Describe how | injury occurre | d |
| Division | Attending r death. sctor: Afte by the fune | atic | Accident Investigation | | | ☐ Yes 2 ☐ No | | | |
| Ž | r Att ter de irect | Ě | 3 ☐ Sulcide 8 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of Injury - At home, fa building, etc. (Specify) | rm, street, factory, office | 9 | 28f. Location (Stre City or Town, | | r or Rure! Route Number, |
| ۵ | To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi | edical Certification: | | | | | | | |
| | Hosp 24 ho Fund Fund stely f | dica | 29a. Certifler (Check only one) Certifying Phy Medical Exami | sician: To the best of my knowledge iner: On the basis of exemination an and menner stated. | e, death occurred at the d/or investigetion, in my | time, dete end plece opinion, deeth occu | , end due to the cau rred et the time, det | se(s) and man e end plece, er | ner es stated. nd due to the ceuse(s) |
| | ithin of the complex c | 2 | 29h Signature and title of cartifier | | 29c. Lice | nse number | 290 | d. Dete signed | (Month, Dey, Year) |
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| | ,6 | - | 30 Name and address of nerven who o | ompleted cause of death (from 02a) | (Type Print) | 0-1-1 | 11 | 7/4 | |
| | 13 | | 30. Name and address of person who co | MO 6569 | N. Charles | ST. B | attorne , | mo 2 | 1204 |
| | Sta | _ | 8 1 11 d (101997, Year) | ruhia Barindisynis Abrolise | 0, | | | | |
| | Registr | | 0 | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27447 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Month 25 SEPT SZYMANSKI 5, WANDA 4e. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Genesis Elder Care -LOCH RAVEN Baltimore LOCH RAVEN If Under 1 Year | if Under 24 Hrs. 5. Sociei Security Number 7. Age (In yrs. lest birthdey) 6. Sex Birthpiece (State or Foreign Country) 8. Dete of Birth (Month, Day, Yeer) 10 M 20 F Months Days Hours Yrs. 200-03-3141 84 FEB 2, 1913 Pennsylvania Usuel Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Md, Baltimore Carney 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3024 Fifth Ave 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo if Yes, Giva Yeer or Detes: 11. Maritei Status Was Decedent of Hispenic Origin? (Specify Yes or No-if Yas, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bieck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 K Divorced WHITE 16e. Decedant's Usuei Occupation 15. Decedent's Education 16b. Kind of Businass/industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) PUBLIC HOSPITAL Stenographer 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Frank Szymanski WAIERYA LONDAL 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Coda) SOPHIA STRAMA 3024 FIFTH AVE - SISTER Balto, Md. 21234 20b. Pieca of Disposition (Neme of camatery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Sept 8 1 Buriai 2 Crametion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) ST Marys Cemetery 1997 Lower Burrell, PA 21. Signature of Funarel Servica Lieeosee 22. Neme end Address of Fecility 23a. Pert1. Entar the disease, or combilications that caused the deeth. Do not enter tha mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause of each line. EVANS CHAPEL OF MEMORIES 8800 Harford Rd Approximate interval Between Onset end Death Obshiber Ling disease immediete Ceuse (Finel diseese or condition resulting in death) Dua to (or es e conseguança of) Sequentially list conditions, if eny, laading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequença of): Due to (or es e consequence of) Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contributa to the causa of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Dependence 24b. Wara eutopsy findings evallable prior to completion of cause of daath? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 26. Piaca of Daath (Check only ona)

Physician /Medical **Examiner**

Examiner

Physician/Medical

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Completed

Be

Certification: To

Physician

/Medical

Examiner

Director

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Completed

Funeral

Director

7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Medical Examiner must be nothed at

permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Introcrant: If Item 27 is marked other than "natural", or item any injury or other traumatic avant

Baltimore, Maryland 21215-0020

the Maryland

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death

bunel-transit pue physician s the buriel 80 950 ed by the detached signed by peen Pass

certificate be executed

Records, P.O. Box 68760, ME of-Vital Division Afte

after deeth Director: 24 hours a

within 2 To the

State Registrar 25. Wes case rafarred to medical axeminer? Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 inpatient 2 ER/Outpetient 3 DOA 28e. Data of injury (Month, Dey Year) 27. Magner of Deeth 28b. Time of 28d. Dascribe how injury occurred 28c. injury et Work? 1 Naturai 2 Accident 5 Pending investigation 1 Yas 2 No 6 Could not be determined 3 Suicide 28f. Location (Streef end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of injury · At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To tha best of my knowledga, deeth occurred at tha tima, data and piace, and dua to tha cause(s) end menner as steted.
2 Madical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at tha tima, date and pieca, and due to tha cause(s) end menner stated. 29a. Cartifier (Check only one)

29b. Signeture end title of cartifier 29c. License number Cilta mp

29d. Dete signed (Month, Dey, Year)

Ballinue, mos 21286

30. Name and eddrass of person who completed cause of death (Item 23a) (Type, Print) Julia Dandson-fundelle

Division of Vital Records, P.O. Box 68760, i or Attending Pi after death. Director: After th 24 hours a

the Maryland

Baltimore, Maryland 21215-0020

2 funeral Certification:

28c. Injury at Work?

1 Yas 2 No 28e. Plece of Injury - At homa, farm, street, factory, offica building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Cartifiar 1🔁 Certifying Physician: To tha best of my knowledga, deeth occurred et tha tima, data and place, and dua to tha cause(s) and menner es stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et tha time, deta end piece, and due to the cause(s) and menner steted.

29b. Signatura and title of certifiar dwal mylam

1 Naturel

2 Accident

3 Suicide

4 - Homicida

5 Pending Invastigation

6 Could not be datarmined

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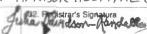
29d. Deta signed (Month, Day, Year) SEPTEMBER 5TH 1997

30. Neme end eddrass of person who complated cause of deeth (Item 23e) (Typa, Print)

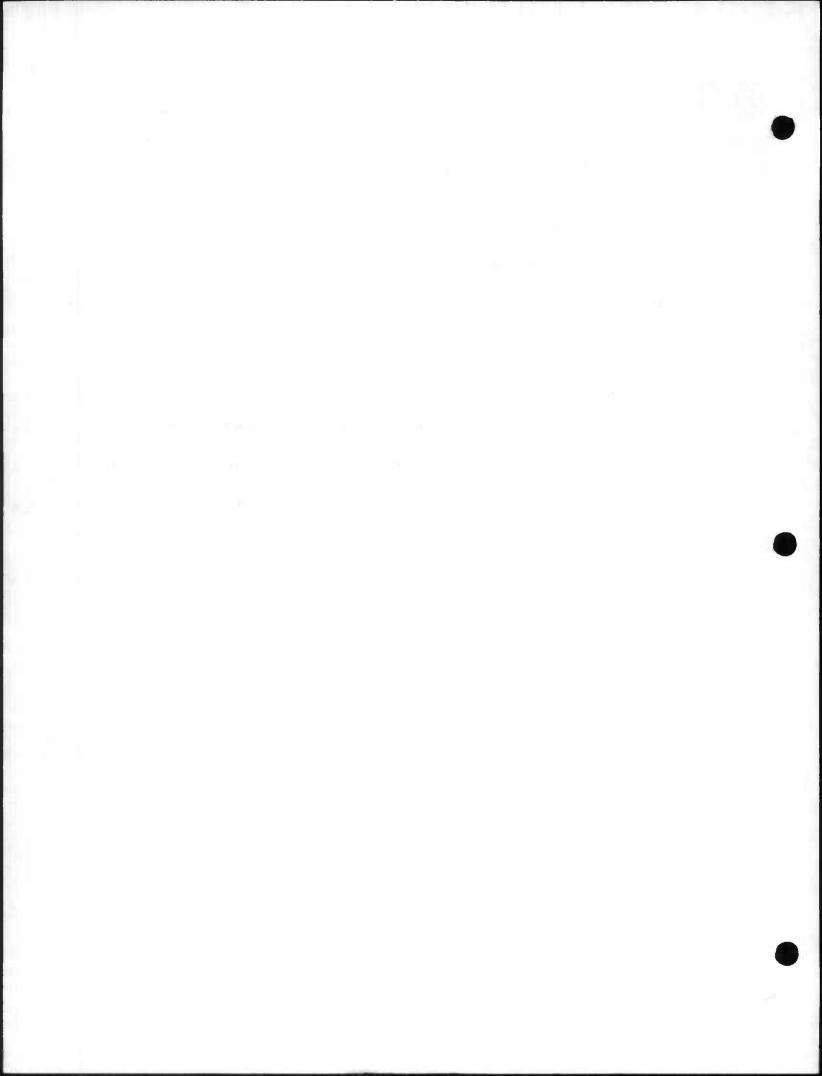
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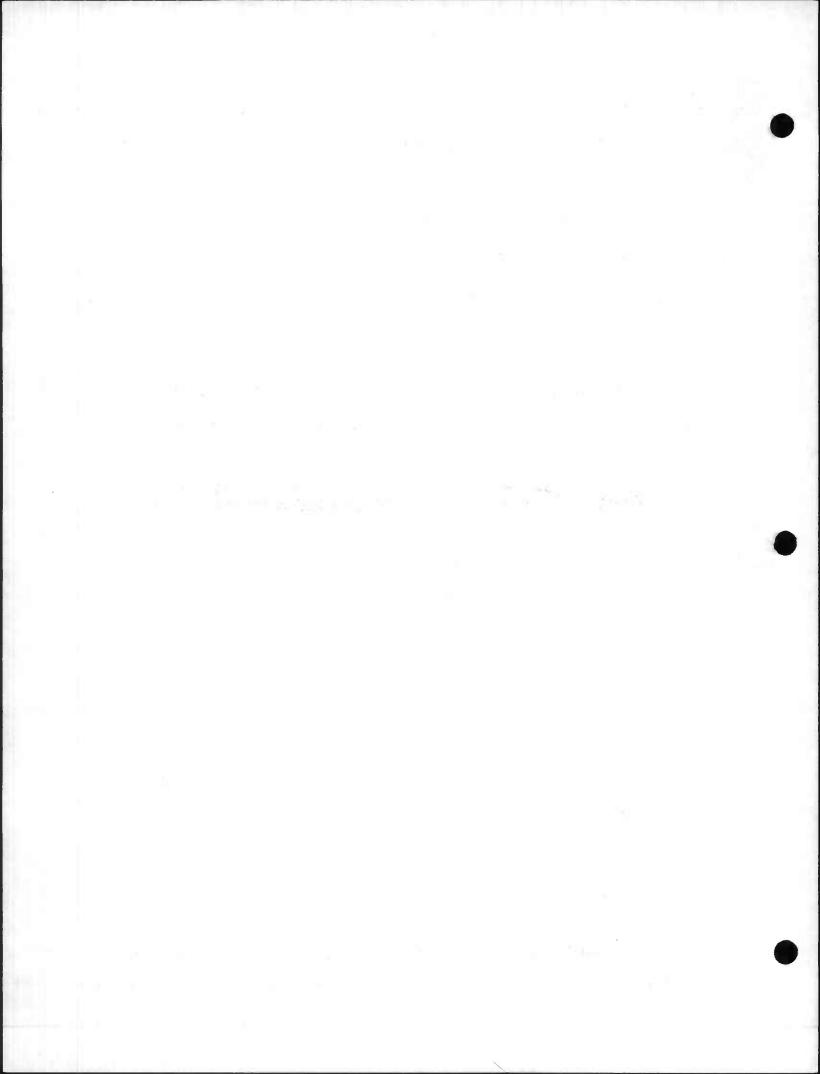


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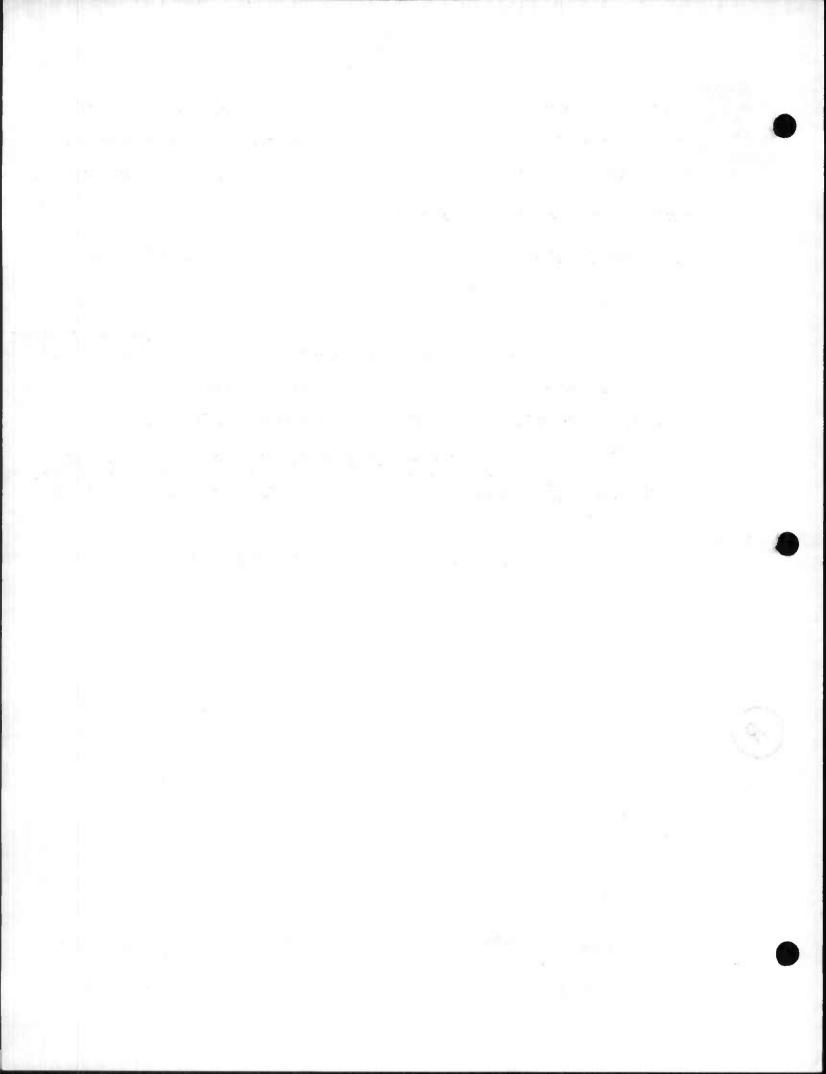
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| 20. Metal Cause (Fine disease or condition resulting in death) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23. Signature of Funeral Service Licensee 22. Name and Address of Facility 23. Signature of Funeral Service Licensee 23. Name and Address of Facility 24. Signature of Funeral Service Licensee 25. Name and Address of Facility 25. Signature of Funeral Service Licensee 26. Name and Address of Facility 26. Signature of Funeral Service Licensee 27. Signature of Funeral Service Licensee 28. Name and Address of Facility STERLING ASHTON FUNERAL HOME, INC. 28. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 38. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 38. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 38. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 38. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 38. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 38. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 38. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 38. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 38. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 38. Part I. | |
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| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | |
| 23b. Did tobacco use contribute to the underlying cause given in Part I. 23b. Did tobacco use contribute to the underlying cause given in Part I. 23c. Was an autopsy performed? 24a. Was an autopsy performed? 24b. We ave contribute to the underlying cause given in Part I. 25c. Was case referred to medical axaminer? 1 Yes 2 No 1 25c. Was case referred to medical axaminer? 1 Yes 2 No 1 25c. Was case referred to medical axaminer? 26c. Injury at Work? 27c. Manner of Deeth investigation investigation and investigation and investigation are underlying cause given in Part I. 26c. Injury at Work? 27c. Manner of Deeth investigation and investigation are underlying cause given in Part I. 27c. Was an autopsy performed? 28c. Place of Death (Check only one) 28d. Describe how injury occurred work? 28d. Describe how injury occurred work? 28d. Describe how injury occurred | |
| 24a. Was an autopsy performed? 24a. Was an autopsy performed? 24b. We save referred to medical axaminer? 1 | he cause of death? |
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| 25. Was case referred to medical axaminer? 1 | e autopsy findings iable prior to |
| Second | pletion of cause eath? |
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| Second | |
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| ≤ Let - ← ← Hornidae Duilding, etc. (Specify) City or Fown, State) | |
| Dullding, etc. (Specify) | Route Number, |
| 29a. Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the ceuse(s) and manner as st (Check only Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piaca, and due to | Roufe Number, |
| and manner stated. 29c. License number 29d. Date signed (Month, I | ted. |
| | ted. he cause(s) |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Todd Baldanza 4940 Eastern Armee Baltimare, Manyland 2123 | ted. he cause(s) ay, Year) |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | ted. he cause(s) ay, Year) |
| State 31. Dele filed (Month, Day, Year) 32. Registrar's Signature State 31. Dele filed (Month, Day, Year) | ted. he cause(s) ay, Year) |
| State Registrar 31. Dete filed (Month, Day, Year) SEP 1 0 1997 32. Registrar's Signature | ted. he cause(s) ay, Year) |



State of Maryland / Department of Health and Mental Hygiene Q 7 271, 50

| | | 1. Decedent's Nem | ne (First, Middle | , Last) | | | | | Death | 1 | 2. Dete of De | Reg. No. eth | | 3. Time of D |
|--|---|---|--|--|--|---|--|---|--|--|--|--|--|--|
| Physic | | | | | | | | | | | Month | Dey | Yeer | |
| /Medi | | Renee M. 4e. Fecility Neme (| | | um hart | <u> </u> | | | th City Town | | Sept. Cation of Deetl | 06, 19 | | 2:00 F |
| Exami | ner | | | | ium <i>oer)</i> | | | | | | | | unty of Deeth | |
| | | Suburban | | | 7 | | . William | der 1 Year | Bethe | - | | | tgamer | - |
| Funeral Director | | 5. Social Security N 331-20-51 Usual Residence of | .31 | 6. Sex 1 ☐ M ② (□) | | rs. lest birtha | Month | | | Min. | 8. Dete of Bir (Month, De Aug. 0 | y, Year) 9, 192 | 9. Birth Col Chic | pplece (Stete or I intry) cago, Il |
| show | | 10a. Stete | 10b. County | | 10c. | City, Town o | or Location | | | | | | | 10d. Inside City |
| 두글 | io | Maryland | Montgo | mery Co. | . K | ensing | gton | | | | | | | 1 Yes 2 |
| 28 | Director | 10e. Street end Nu | imber | | | | 10f. 2 | Zip Code | | - | | 10a. Citizen | of Whet Cou | intry? |
| 2 2 | | 2222 Ibeir | mraitu | הייות | | | | 0895 | | | | | | |
| 8 2 | era | 3333 Univ | ersicy | | cedent Ever in | U.S. | | | ispenic Origin | n? (Sne | cify Yes or No | United States No- 14. Rece - American Indien | | |
| one. than "naturel", or items 23s or 28s-1 show re Medical Examiner must be notified at | by Funeral | 11-2-12-13-11 | ried 2□ Marrie | Armed F | Forces? 2 [33]No Bive | | | pecify Cube 2 XNo | | Puèrto f | cify Yes or No Rican, etc.) | | Bleck, Whita | |
| cel | | | 15. Decedent's | s Education | | 18e. De | ecedent's Us | suel Occup | etion | | | 16b. Kind o | of Business/I | ndustry |
| A STATE OF | Completed | | cify only highest | grade completed | • | (G lif | Give kind of vife. DO NOT | work done usa retired | etion du <i>ring</i> m <i>ost o</i> f) | f workir | g | | | ion/Nat |
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| | | Lynda D. Hester (Daughter) 444 Range Road Towson, Maryland 21 | | | | | | | | | | ,/ | | |
| | | 20e. Method of Dis | | | 20b. Plece of Disposition (Nema | | | | | | Dete | | on - City or T | Town, Stete |
| | | | | Alori 3 Linemove nom stata | | | | | | | | | | |
| | 4 Donetion 5 Other (Specify) Hilltop Service Corp. 9/08/97 Tows | | | | | | | | | | | | | |
| any in | | Dy | Juz | 7 | ar. | Gall | ZZ. Neme | end Addra | ss of recility | | | | | Md. 212 |
| ysician | | shock, or hee | ert feilure. List o | only ona cause on | caused the de eech line. | eeth. Do not | t entar the m | ode of dyin | g, such es ca | ırdiec o | r respiretory e | rest, | | Approximete intervei Betwe Onset and De |
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| ctor: After this certificate has been expressed to use as the bunat-transit in property the function page 2 should be defined for use as the bunat-transit in property in the function page 2. | To Be Completed by Physician/Medical | immedieta Causa disease or condition resulting in daeth) Sequentielly list condition of the cause. Enter Undo Cause (Disease or the tinitiated evant resulting in deeth) Pert ii. Other eignification of the cause (Disease or the tinitiated evant resulting in deeth) Pert ii. Other eignification of the cause (Disease or the tinitiated evant resulting in deeth) 25. Wes casa rafar axaminer? 1 | (Finel on onditions, mediate arriving larger | b. c. d. Hospital: 28a. Dete (More build) 28e. Plec build Phyelclan: To the kexeminer: On the be | Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to | o (or es e con o (or es e con o (or es e con resulting in the con con con con con con con con con con | atient 3 Ine of unvestigation investigation 2 | DOA Oth 28c. Injun Word on, in my op | Policies of Place of | f Death If Deat | 23b. Did 1 24a. Was perfo | cobacco use Yes 2 N en autopsy med? Yes 2 N chence 6 D now injury oc Street end N wn, Stete) ceuse(s) enc data and pla 29d. Date si | 24b. V | Intervel Betwee Onset and De De De De De De De De De De De De De |
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death 3 Time of Death Month SC HROEDER GEORGE 15:52 Sent 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Howard County General Hospital Columbia Howard 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Dete of Birth (Month, Day, Year) Birthpiece (State or Foreign Country) Days 1**⊠**M 2□ F 214-54-6969 June 18, Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits Howard Ellicott City 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3345 N. Chatham Rd. 21042 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Bace - American Indian Bieck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16h Kind of Business/Industry Baltimore City Elementery/Secondery (0-12) College (1-4or 5+) 12 Zoning Inspector 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Elizabeth A. Meineke Louis F. Schroeder 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis Schroeder (Brother) 2018 Red River Rd. Eldersburg, MD 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Sept Dete 20c. Location - City or Town, Stete 1

Burial 2 □ Cremetion 3 □ Removel from Stete
4 □ Donetion 5 □ Other (Specify) 6, 1997 Meadowridge Cemetery Dorsey, MD 21. Signeture of Funerel Service Ligensee Witzke Funeral Homes, Inc. 5555 Twin Knolls Rd. Columbia, MD 21045 23a. Pen1. Enter the disaase, or complications hat caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or haert failure. List only one ceuse on each lina. Approximete Interval Batween Onset and Deeth Immediata Ceușe (Final Malignant Ventricular Arry min disease or condition resulting in deeth) Haute Myocardial hours.

Physician /Medical Examiner

been signed by the s should be detached

certificate

this

To the Hospital within 24 hours a To the Funerei C completely filled

Physician/Medical

Completed

Be

Certification:

Medical

certificate be executed attending physician end for use as the burial-transit

Records, P.O. Box 68760.

Wision of Vital

permit. Pages 1 and 2 a Department of Heelth ar important: if fem 27 to any injury or other trau once.

Physician

/Medical

Examiner

10a. Stete

Director

Funeral

p

Completed

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Funeral

Director

rthan "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after deeth with inent of Heelih and Mentel tyglene.

ant: if item 27 is marked other than "natural", or items 23s or it in yor other traumate event, the Medical Earning mast be any or other traumate event, the Medical Earning mast be.

altimore, Maryland 21215-0020

the Meryland

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Last

Atherosdevotic Cardiovascular disease Due to (or es e consequence of)

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Schizophrenia, 4/0 Malignant tumor (D) pelvic ~ 1byrys (7. osteosarcomA) 25. Wes case raferred to medical 28. Place of Deeth (Check only one)

23b. Did tobacco use contribute to the cause of death? 1 No 2 No 3 Probably 4 Unknown

24a. Wes en eutopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

1 Yes 20 No

axaminer? 27. Menner of Death

28a. Deta of Injury (Month, Day Year) 5 Pending Investigation

A. TOTE, MD

28b. Time of

28a. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

4565

1 ☐ Inpatient 2 ☐ PR/Outpatient 3 ☐ DOA 28c. injury et Work?

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

Hemlock Cone way Ellical Coty MD 21012

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e, Certifier

1 Naturel

2 Accident 3 Suicide

4 I Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as steted.

2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, daath occurred at the time, dete end place, and dua to the cause(s) end menner stated.

29b. Signature and title of certifier 30. Nema and address of person who complated cause of death (itam 23a) (Type, Print)

6 Could not be determined

29c. License number

29d. Dete signed (Month, Day, Year)

PATTINGCE State

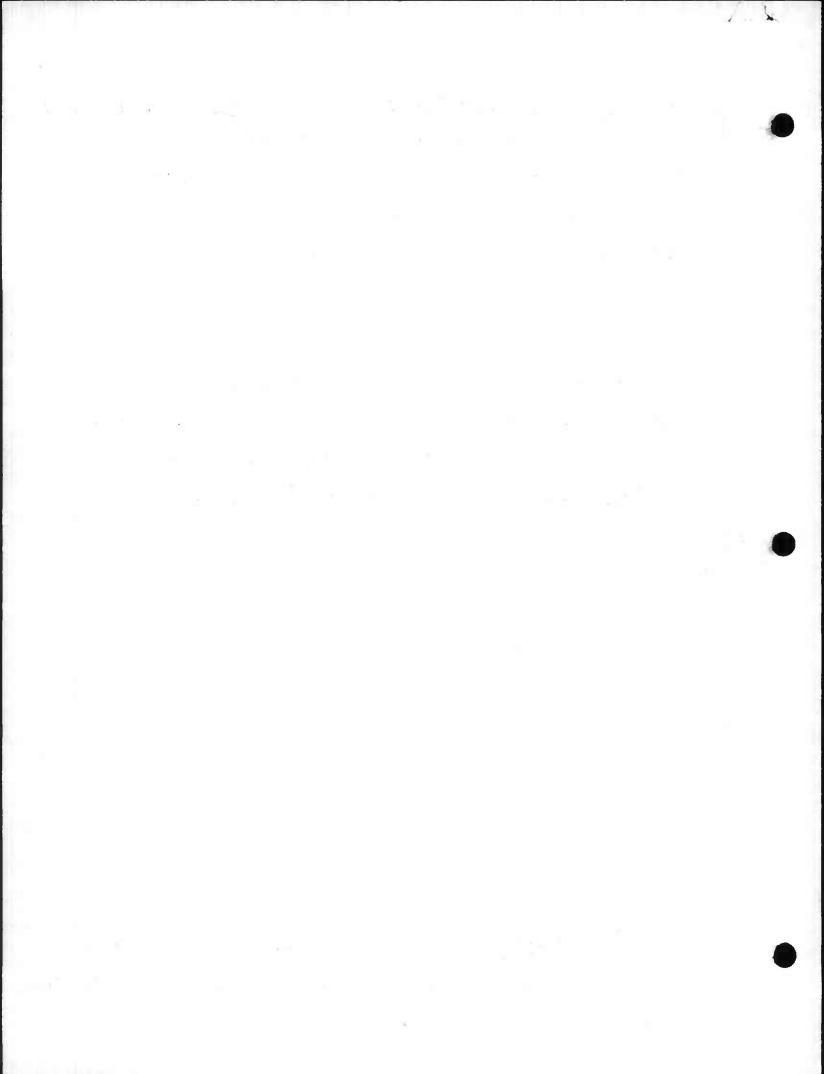
31. Dete filed (Month, Dey, Yeer)

32. Registrer's Signeture

DHMH 16 Ray 6/95

Registrar

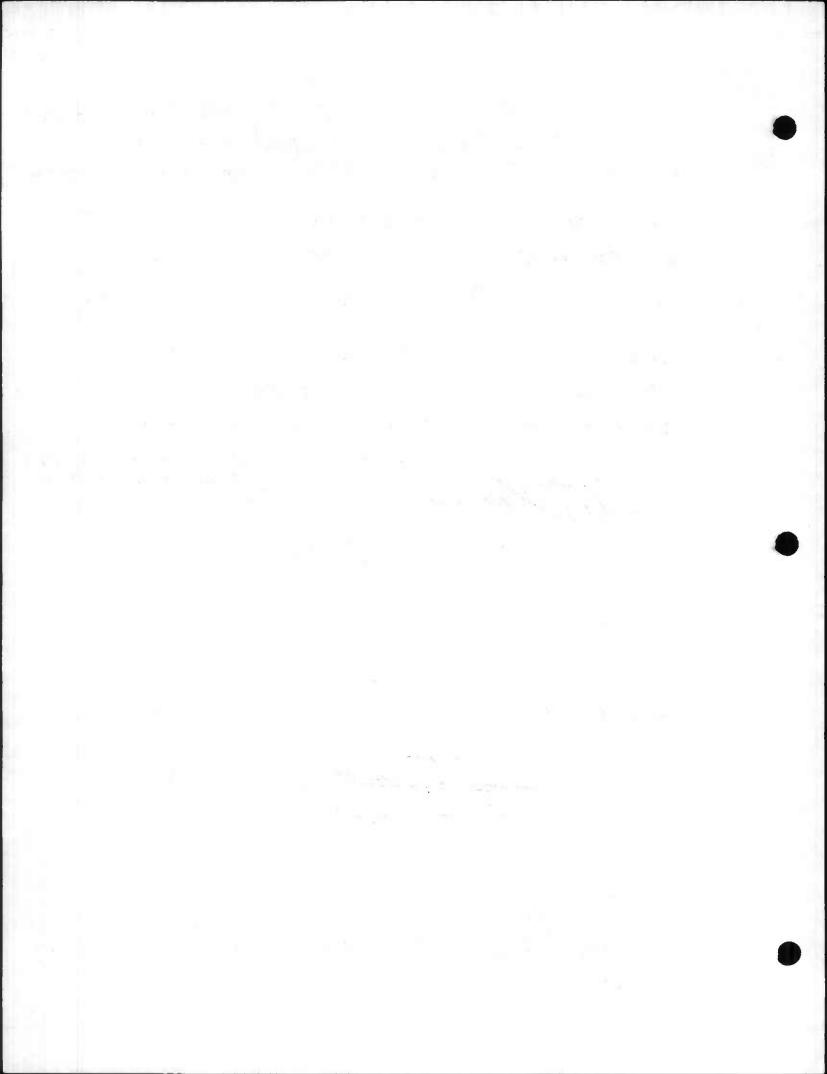
Achia Bairds



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Gertificate of Death

| | Item | 18 | Per FH Film G751 9-10- | 97 rja | | ate of Death | | Reg. No. | 7 27 | 452 |
|-------------------|--|-----------------|--|---|---|---|--|----------------------|--|--------------------------------------|
| | Physic /Medi | cai | 1. Decedent's Name (First, Middle, Last | Scott | | 4.00 7 | 2. Date of Dea | miles T | 7, 1997 (| ime of Death |
| | Examir Funeral Director | ner | 4a. Facility Name (If not Institution, give Singui Hogy Hogy 16. Se Social Security Number 6. Se 15. Social Residence of Decedent | e of butter | Mont | nder 1 Year II Under 24 I | or Location of Deeth Ars. 8. Date of Birtl In. (Month, Da) JUN 11 | N/A | | |
| | show | _ | 10a. State 10b. County | 10c. Cit | ty, Town or Location | | | | | ilde City Limits |
| | the Me 28s-4 s | Director | MARYLAND N/A 10e. Street and Number | | BALTIMO | | | 10- 011 | |]Yes 2□No |
| | 3e or | I Dir | 3706 FAIRVIEW AVE | NIIF | TOI. | Zip Code 21216 | | 10g. Citizen of V | | |
| 020 | 72 hours after death with the Maryland natural, or items 23e or 28s-f show dical Examiner must be notified at | by Funeral | 11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ever In U Armed Forces? 1 Yes, Give Year or Dates: | | ecedent of Hispanic Origin's specify Cuban, Mexican, Post 2/2/2000 Specify: | (Specify Yes or No- lerto Rican, etc.) | 14. Race Blace | e - American Indi k, White, etc. | ien, |
| 21215-0020 | C 68 | Completed | 15. Decedent's Edu (Specify only highest gred Elementary/Secondary (0-12) | | | work done during most of Tuse retired) | working | | siness/industry | |
| | filed within Hygiene. Ither than | | unknown 17. Father's Name (First, Middle, Last) | | HOUSEW | | Name (First, Middle, | HOME Malden Sumam | (e) | |
| /lan | should be filed nd Mental Hygi marked other umatic avent, t | To Be | ALBERT JONES | | | | NE WALKER | | | |
| Maryland | 2 sho lend h ls me raume | | 19e. Informant's Name/Reletionship (7) | ype, Print) | _ | ress (Street and Number o | Rural Route Numbe | | State, Zip Code) | |
| Baltimore, I | permit. Peges 1 and 2 should be filed within Department of Health end Mental Hygiene. Important: If item 27 is marked other than appring yor other traumatic avent, the Madde. | | Willie James Walk 20a. Method of Disposition XXBuriel 2 Cremation 3 F 4 Donetion 5 Other (Specify) | 20b. F Removal from State | 372 Dry Place of Disposition (cemetery, crematory) WNSVILLE | or other placa) | Aiken, S. | 20c. Location - | City or Town, St | |
| Balti | permit. Pages Department of Important: If it any injury or o | | 21. Signature of Funeral Service 1 | Beau | | and Address of Facility W | | BROWN C | COMMUNIT | Y F/H |
| | Physician /Medical Examiner | iner | 23a. Part1. The this ase, shock, which are failure. List only of limited the cause (Final disease or condition resulting in death) | . Intraca | | emorhege | | | thterv Onset | oximate al Between t end Death |
| 68760, | ifficate be executed g physician and es the bunal-transit | edical Examiner | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last | с | or as a consequence | | | | | |
| Box | | an/M | | d | | | | | 1 | |
| P.O. | law requires that the death cert as been signed by the attending 2 should be detached for use | by Physician/M | Pert tt. Other significant conditions con | ntributing to death but not res | ulting in the underlying | ng cause given in Pert I. | 23b. Did t | 1/ | atributs to the ca | auss of death? |
| of Vital Records, | e law requires has been sign ge 2 should by | Completed b | | | | | | an autopsy med? | 24b. Were eut availeble completic of death? | prior to on of cause |
| alB | The ate h | | | | | | 1□ Y | es No | 1 🗆 Yes | 25 No |
| Vit. | Physician: The this certificate ral director, per | To Be | 25. Was case referred to medical examiner? | Hospitel: 1 Inpatient 2 | I ER/Outpatient 3□ | Other: | Death <i>(Check</i> only o | | or (Specifu) | |
| DIVISion of | ath bath or Atter this | | 27. Manner of Death Natural 5 Pending investigation | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | | ow Injury occurr | | |
| DIVI | offs effective | Certification: | 3 Suicide 6 Could not be determined | 28e. Piaca of Injury - At he building, etc. (Specify | (y) | | City or Tow | n, Stete) | er or Rurel Route | Number, |
| | 9 6 6 > | edical | 29a. Certifier Contifier (Check only 2 Madical Examination) | sician: To the best of my kno nar: On the basis of examina end menner stated. | wiedge, deeth occuri ition and/or Investigat | lon, in my opinion, death o | ace, and due to the o courred at the time, o | dete and place, a | and due to the ca | ıuse(s) |
| | To the Fu within 24 I To the Fu completely | M | 29b. Signature and title of certifier Washington | Su m | 7.D. | 29c. License number AS 24023 | - 1 | 29d. Date signed | Sept 7 | 1997 |
| | 10 | | 30. Name and address of person who co 111AY ANN SCRRA 31. Date (iled (Month, Day, Year) | ompleted ceuse of death (Item 2401 W. BELL 32. Registrar's Signa | JEDERE A | IE, BALTIMI | RE, MI) | | 1 | |
| | Sta Registr | | SEP 101997 | Sz. negistrar s signa | | | | | | |

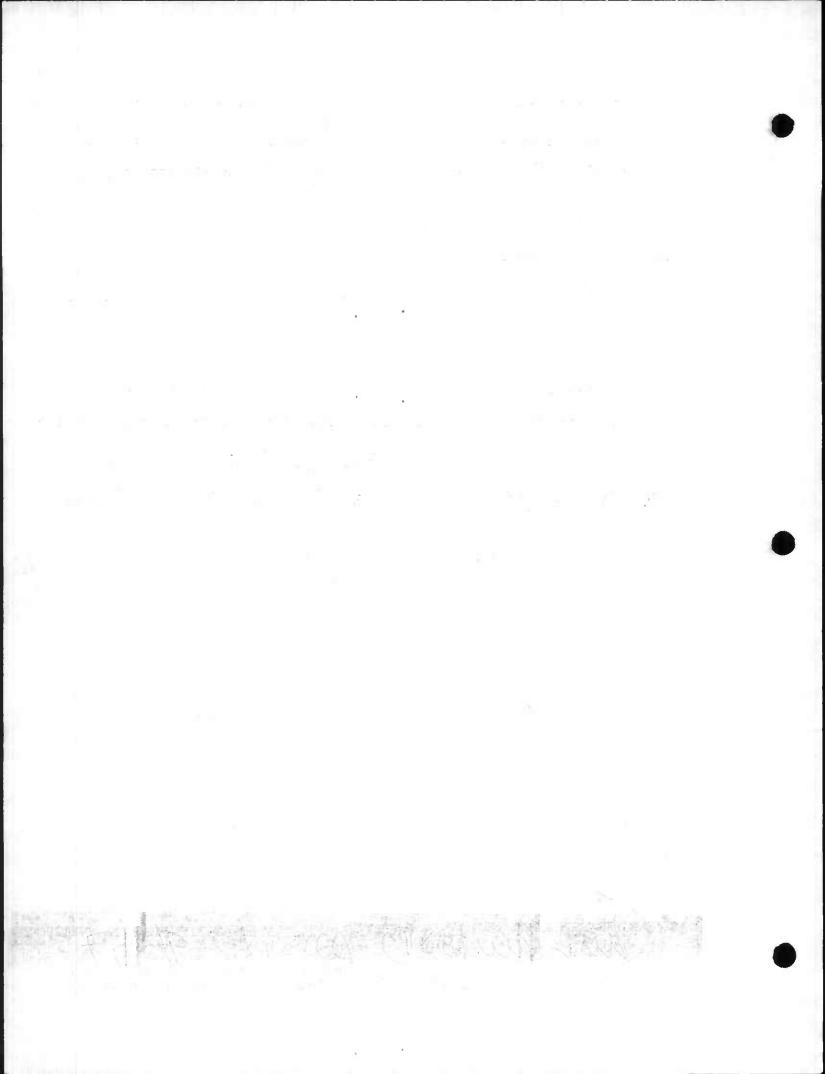
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Q 7

| | | | | | Cer | tificate of | Death | | Reg. No. | 1 6 | 1400 | | |
|--|------------------|--|------------------------------|----------------------------------|----------------------|--|-----------------------|-----------------------|--|---------------|---|--|--|
| Dhue | iolon | 1. Decedent's Name (First, Middle, | | | | | | 2. Dete d | | Veer | 3. Time of Death | | |
| | sician edical | Floyd Delano T | racey | | | | | Septe | mber 2, 1 | 9 97 ° | 2:15 p.m. | | |
| | miner | 4e. Fecility Neme (If not institution, | | | | | 4b. City, To | wn, or Location of I | Deeth 4c. Count | y of Death | | | |
| | | 20930 Middle | | | | With-day 4 William | | eland | | timo | re | | |
| Funer | | 5. Social Security Number 219-36-0502 | . Sex 7. 1 M 2 □ F | '. Age <i>(In yrs. l</i> e 60 | st birthdey) Yrs. | If Under 1 Yee Months Deys | - | Min. 8. Dete c | h 10, 1937 | Coun | | | |
| Direct | or | Usuel Residence of Decedent | | 00 | 710. | | | Marc | n 10, 1937 | Mar | yland | | |
| Mand Mand | | 10e. Stete 10b. County | | 10c. City, | Town or Loc | Location 10d. Inside | | | | | | | |
| Man Ha | ţ | MD Balti | more | F | reela | ind | | | 1 🗆 Y | | | | |
| r 284 | Director | 10e. Street end Number | | | | 10f. Zip Code | | | 10g. Citizen of | What Coun | itry? | | |
| h wit | O | 20930 Middle | town Rd | • | | 2105 | 3 | | U.S. | A. | | | |
| deat | Funeral | 11. Maritel Stetus | 12. Wes Deced Armed Force | ent Ever in U,S | . 13. V | Vas Decedent of | Hispenic Orig | gin? (Specify Yes o | r No- 14. Re | ce - Americ | | | |
| after of the | 臣 | 1 Never Merried 2 Married | | 2 X No | | ☐ Yes 2 No | | , r dello riloan, etc | Special Specia | ck, White, | nite | | |
| 5-0020 72 hours after death with the Manyland natural; or frame 23a or 28a-f show of all Examines must be notified at | d by | 3 Widowed 4 Divorced | Yeer or Det | | | | оросу. | | Зресп | y | | | |
| 15- 721 | ete | 15. Decedent's (Specify only highest | Education rede completed) | | 16a. Deced | ent's Usuel Occu kind of work done O NOT use retin | petion during most | of working | 16b. Kind of E | Business/Inc | Justry | | |
| within one. | Completed | Elementery/Secondery (0-12) | College (1-4 | 4or 5+) | • | : Drawe | | | Wire | Clos | t h | | |
| The Had | Ü | 17. Fether's Neme (First, Middle, La | st) | | | Diame | | r's Neme (First, Mi | ddle, Meiden Sume | | W 2 2 | | |
| arylan should be and Mental | To Be | Vernon Trace | У | | | | Kat | ie Viro | inia Tr | acey | | | |
| Maryland 21215-0020 d 2 should be filed within 72 hours at th end Mental Hygiene. 77 ia marked other than "natural", or traumatic avent, the Woot or Exon | - | 19e. Informant's Nema/Reletionship | (Type, Print) | | 19b. Mallin | g Address (Stree | | | umber, City or Town | | Code) | | |
| 1 and 2 Health e | | Betty A. Trace | y/Wife | | 2093 | 0 Midd | letow | n Rd., | Freelan | d, MI | 21053 | | |
| ~ _ | | 20e. Method of Disposition 1 Durial 2 XCremetion 3 | Y-10 | Cer | metery, crem | sition (Neme of setory or other pla | 9 <i>ce</i>) | Dete | 20c. Location | - City or To | wn, Stete | | |
| Pages nent of I and: If its | | 4 Donetion 5 Other (Spe | | Yor | ktowne | Casket n Serv | s, Inc. | Sept. 4 | York, | PA | | | |
| Baltimo permit. Page: Department of Important: If it any Injury or | DUCE | 21. Signature of Funeral Service Lic | ensee | | 22. | Neme end Addr | ess of Fecility | , | | _ | | | |
| m goes | a | Xour D | 12. | | 2 | 4 Secon | rtens d St. | tein Mo . New Fr | rtuary, | Inc. | 7349 | | |
| 0 | | 23a. Pert1. Enter the disease, or co shock, or heart fellure. List or | mplications that cau | used the deeth. | Do not ente | r the mode of dy | ing, such es | cardiac or respireto | ory arrest, | | Approximate Interval Between | | |
| Physicia | _ | Onset and Dec | | | | | | | | | | | |
| /Medic Examine | _ | Immediate Cause (Finel disease or condition resulting in deeth) Due to (or es a consequence of The Lung | | | | | | | | | | | |
| | 6 | | | Due to (or | es a consequ | Jence of ATL | uem | NQ | | | Ry | | |
| thed trisit | Examiner | | J | | | • | | | | | | | |
| x 68760, ertificate be executed ling physician and ee the burial-transit | Exa | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | | Due to (or a | es e consequ | ience or): | | | | | | | |
| 68760, ificate be expensed physician es the burial | edicai | Cause (Diseesa or Injury that initiated events | C | Due to (or e | es e consequ | ence of): | | | | | | | |
| of the set | Med | resulting in deeth) Last | | 545 15 (51) | , | 01,00 | | | | | | | |
| | an/M | | d | | | | | | | | | | |
| | Physician | Pert II. Other significant conditions | contributing to deat | th but not result | ting in the un | derlying cause g | iven In Pert i. | 23b. | Did tobacco use co | ontribute to | the cause of death? | | |
| P.O. do by the setache | £ | Severe | COVI |) | | | | | Yee 2□ No 3□ Probably 4 | | | | |
| Signe the ded | þ | | - 01 0 | | | | | | | | | | |
| Records, he law requires the has been signe | Completed | | | | | | | | Was an autopsy performed? | 9V8 | ere autopsy findings alleble prior to mpletion of cause | | |
| The law rate has by page 2 s | igh. | | | | | | | | . / | of | deeth? | | |
| al The | | | | | | | | | 1□Yes 2000 | 1[| Yes 2□ No | | |
| Division of Vital I or Attanding Physician: The after death. Director: After this certificate I in by the funeral director, pag | 8 | 25. Wes case referred to medical examiner? | Hospitel: | | | _ 0 | hor: | of Deeth (Check of | | | | | |
| Phy Physics of the ph | 5: | 1 ☐ Yes 2 ☐ No 27. Mepner of Death | 1 ∐ Inp | Injury 2 | R/Outpatient | 3LI DOA | 4LI NUI | | Residence 8 □Ot ribe how Injury occu | | 0) | | |
| On ding if | to | 1 Naturel 5 Pending 2 Accident Investigat | (Month, | Dey Year) | Injury | 28c. Inju Wo M 1 | ork?]Yes 2∐h | | ,, | | | | |
| DIVISION Attandation of the Control | #ICa | 3 Suicide 8 ☐ Could not | be on Disease | f Injury - At hom | ne, ferm, stre | et, fectory, office | | 28f. Locati | on (Street and Num | ber or Rura | l Route Number, | | |
| Z Para | Certification | 4 Homicide | building | , etc. (Specify) | | | | City o | r Town, Stete) | | | | |
| Division of the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral | | 29e. Certifier Certifying I | hysician: To the be | est of my knowl | edge, deeth | occurred et the t | lme, dete end | d plece, and due to | tha cause(s) and m | anner as st | ated. | | |
| the Him 24 the Fu | edical | one) 2 Medical Ex | th occurred et the t | me, dete and piece, | and due to | the cause(s) | | | | | | | |
| Se Tripital | Σ | | | | | | | | | Monta. | Day, Year) | | |
| | | 1 musiculus 1 200574 9/3/9- | | | | | | | | | | | |
| | | 30. Name and address of person wh | | | | | | | e Medica | | nter | | |
| | | Ruth Kantor, | | | | n Char | les S | t., Bal | timore, | MD 2] | 1204 | | |
| Regi: | State | 31. Dete filed (Month, Dey, Year) SEP 1 0 1 | 997 32. Reg | Istrer's Signetu | 10 | | | | | | | | |
| negi: | enai | 071 10 | 70. | ha David | or-Han | telle | | | | | | | |

DHMH 16 Rev 6/95



Physician /Medica Examine

Funeral

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylend Department of Health end Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show eny injury or other traumatic event, the Medical Examinat must be not that an once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0020

Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible.

| | st) | Cer | | | 2. Date of D | Reg. No. | | 3. Time of Death | |
|--|--|--|---|---|-------------------------------------|---|---|--|--|
| BOBBY STAN | LEY TAYLOR | | | | Month | MBER 03 | Year 1997 | 9:29 P | |
| 4e. Facility Name (If not institution, giv | e street and number) | | | 4b. City, Town, | or Location of Dea | T . | y of Death | J. 2.J. I | |
| 4800 BLK.QWYNN OA | K IN THE REAF | ALLEY | | BALTIMO | RE | | N/A | | |
| 5. Social Security Number 6. S | | s. last birthday) | if Under 1 Yea | | Hrs. 8. Date of Bi | rth av Vaarl | 9. Birthpiad | e (State or Foreig | |
| | X M 2□ F 3 | 3 Yrs. | WOTHING Day | 3 Flourd | 01/31 | 7 1964 | Wash. | , D.C. | |
| Usual Residence of Decedent 10a. Stata 10b. County | 100.0 | City, Town or Lo | nation | | | | 100 | Inside City Limit | |
| MD N/ | | BALTI | | | | | | | |
| 10e. Street and Number 5 3 1 3 BELLEVIL | LE AVENUE | A V E N U E 10f. Zip Code 10g. Citizen of W U. | | | | | | | |
| 11. Maritei Status 1 ☑ Never Married 2 ☐ Married | 12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give | it | Vas Decedent of Yes, specify Co | uben, Mexican, P | (Specify Yes or Nuerto Rican, etc.) | | ce - American ack, White, etc | | |
| 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed | Yeer or Dates: | 16e. Deced | ent's Usual Occ | upation | | 16b. Kind of B | | trv | |
| (Specify only highest gra Elementary/Secondary (0-12) 12th | de complated) Collaga (1-4or 5+) 2 | (Give | kind of work dor DO NOT use reti utcher | ne during most of red) | working | | Store | ., | |
| 17. Fathar's Name (First, Middia, Last) Bobbie Taylor | | | | | Name (First, Middle | | m <i>e)</i> | | |
| 19a. Informant's Name/Relationship (| Type, Print) | 19b. Mailin | g Address (Stre | et and Numbar o | Rural Route Numb | er, City or Town | , State, Zip Co | oda) | |
| Laura Taylor | | 5313 | Belle | ville A | venue, | Balto. | , MD | 21207 | |
| 20e. Method of Disposition | | Piace of Dispos | sition (Name of natory or other p | daca) | Date | 20c. Location | - City or Town | , State | |
| ty□ Burial 2 ☐ Crametion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifi | | Kini | 2 Pin | o K | 9-8-97 WOOD AUIL | | | | |
| 21. Signature of Funeral Service Ligar | See O A | - 22 L | hame and Add | Press of Filipity | 1 1 | FUNERA | | E, P.A | |
| meroy C | . Descu | | | | REIGHTS | AVE.,B | | | |
| 23a. Raft Anter the disease, or companies to heart tallure. List only | olicetions that raused the decone ceuse of the children. | ath. Do not ente | or the mode of d | ying, such es car | diac or respiratory e | rrest, | In | proximate tervai Between | |
| U | 14 01 | | | | | | 0 | nset and Deeth | |
| Immediata Causa (Final diseese or condition resulting In death) | a Phult, | 1/2 G4 | inshot | Woun | Os | | | | |
| Tooling III dadiiy | Due to | r as a conseq | uence of): | | | | | | |
| | b | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying | Dua to | (or as a consequ | | | | | | | |
| Annual Cata China to 1 th | 6 | | uence of): | | | | | | |
| Cause (Disease or injury | U | | uence oi): | | | | | | |
| ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Dua to | or as a consaqu | | | | | | | |
| that initiated events | Dua to (| or as a consaqu | | | | | | | |
| Cause (Disease or injury that initiated events resulting in death) Last | d | | uence of): | | | | | | |
| that initiated events | d | | uence of): | given in Part I. | | tobacco uae co | ontribute to th | e ceuse of death ly 4 □ Unknoo | |
| Cause (Disease or injury that initiated events resulting in death) Last | d | | uence of): | given in Part I. | 1 □ | | 3 Probab 24b. Were evalia comp | 4 Unknown | |
| Cause (Disease or injury that initiated events resulting in death) Last | d | | uence of): | given in Part I. | 1 □ | Yee 2500 | 3 Probab | eutopsy findings ble prior to etion of ceuse th? | |
| Cause (Disease or injury that initiated events resulting in death) Last Part II. Other algnificant conditions of the co | d | | uence of): | | 1 □ | en eutopsyormed? | 3 Probab 24b. Were evalia comp of dea | eutopsy findings ble prior to etion of ceuse th? | |
| Cause (Disease or Injury that initiated events resulting in death) Last | d | | uence of): | 26. Place of | 24a. Wes perf | en eutopsyomed? Yes 2 No | 3 Probeb 24b. Were evalia comp of dec | eutopsy findings ble prior to eltion of ceuse th? es 2 \(\text{No} \) | |
| Cause (Disease or injury that initiated events resulting in death) Last Part II. Other algnificant conditions of the c | dontributing to death but not re | sulting in the un | uence of): idarlying cause s | 26. Place of Other: 4□ Nursin jury et | 24a. Wesperf | en eutopsyomed? Yes 2 No | 3 Probab 24b. Were evaila comp of dee | eutopsy findings ble prior to eltion of ceuse th? es 2 \(\text{No} \) No | |
| 25. Was cese referred to medicel examiner? 1 Yes 2 No 27. Manner of Deeth 1 Netural 5 Pending 2 Accident invastigation | d | sulting in the un | uence of): adarlying cause graders and the second | 26. Place of ^{Xthar:} 4□ Nursin | 24a. Wesperf | Yee who en eutopsy ormed? Yes 2 □ No one) dence 6 ▼IOth | 3 Probab 24b. Were evaila comp of dee | eutopsy findings ble prior to eltion of ceuse th? es 2 \sum No | |
| Cause (Disease or injury that initiated events resulting in death) Last Part II. Other algnificant conditions of the c | d | ER/Outpatient 28b. Time of Injury 2/ 2/ | and DOA Carbon Mark 11 Mark 1 | 26. Place of Other: 4 □ Nursin jury et lork? □ Yes 2 ☑ No | 24a, Wesperf | Yee who en eutopsy ormed? Yes 2 □ No one) dence 6 ▼IOth | 3 Probab 24b. Were evalia comp of dea | eutopsy findings ble prior to eltion of ceuse th? es 2 \sum No ALLEY | |

OCME

29d. Date signed (Month, Day, Year)

SEPTEMBER 04,1997

es that the death certificate be executed rds, P.O. Box 68760, Division of Vital To the Hospital or Attending Physicial within 24 hours after death.

To the Funeral Director: After this certil completely filled in by the funeral direct

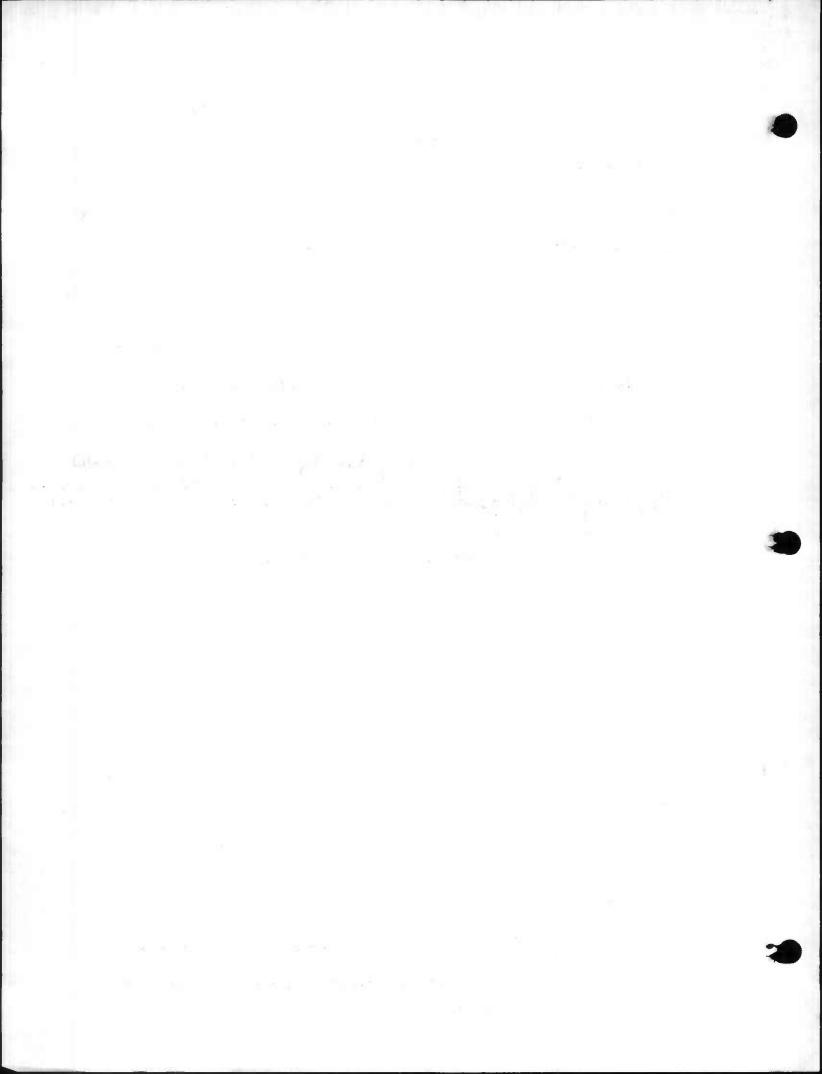
State Registrar

Dennis J. 31. Date filed (Month, Day, Year) SEP 1 0 1997

29b. Signature and titla of certifier

Chuteno 111 Penn Street, Baltimore, Maryland 21201

complated cause of death (Item 23a) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene 27455 Certificate of Death

| Physician |
|-----------|
| /Medical |
| Examiner |
| |

1. Decedent's Name (First, Middle, Last) Carole Jean Teets

Sept. 4b. City. Town, or Location of Death

2. Dete of Death

Month

Bay 8 1997 0049 4c. County of Death

Funeral Director

Directo

Funeral

þ

Completed

Pages 1 end 2 should be filed within 72 hours efter death with the Maryland nent of Health and Mentel Hygiene. nt: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show "natural", or items 23s or 28s-f show edical Examiner must be notified at the Medical 7 is marked other traumatic event.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Examiner

Physician/Medicai

þ

Be

2

Certification:

Medical

= 5 permit. Page Depertment I Important: If any injury o

physician and the bunal-transit The law requires that the death certificate be executed attending pl ed by the a bengis page 2 should director.

Division of Vital Records, P.O. Box 68760,

After this certificate has Hospital or Attending Physician: 24 hours effer death. Funeral Director: After this certifice funeral To the Hospital c within 24 hours of To the Funeral D completely filled i 4a. Facility Neme (If not institution, give street and number) Carroll Co. Gen. Hospital 5. Social Security Number 6. Say 7. Age (In yrs. last birthday) 1□M 2XF 219-34-2301

Westminster If Under 24 Hrs. 8. Dete of Birth (Month, Day, If Under 1 Year

Carroll Birthplece (State or Foreign Country) 11,1940 Maryland

Usual Residence of Decedent 10e Stete 10h County 10c. City. Town or Location Maryland Carroll

Manchester

Yrs.

10d. Inside City Limita 1 Yes 2 No

3 Time of Death

10e. Street and Number 3032 Walnut St. 11 Marital Status

1 ☐ Never Merried 2 Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:

21102 Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:

U.S.A. Race - American Indien, Black, White, etc.

10g. Citizen of What Country?

Specify:

16b. Kind of Business/Industry

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bus Driver

Days

Towson University

White

17. Father's Name (First, Middle, Last)

10f. Zip Code

18. Mother's Name (First, Middle, Malden Surname)

Fernard Eckert 19a. Informant's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify)

Thelma Ryan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Harvey A. Teets - husband 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State

20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Sept. 11,1997 Baltimore. Md.

3032 Walnut St. Manchester, Md. 21102 20c. Location - City or Town, State

21. Signature of Funeral Service Licensee List

22. Name and Address of Facility
Eckhardt Funeral Chapel
3296 Charmil Dr. Manchester, Md. 21102 Approximete interval Between Onset and Death

23e. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart tailure. List only one cause on each line.

Ca

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Finel

diseese or condition resulting in death)

Due to (or as a consequence of)

Due to (or as a consequence of)

Due to (or as a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death?

reter Mellite

10 Yes 2 No 3 Probably 4 Unknown 24e. Wes en eutopsy performed?

24b. Were autopsy tindings available prior to completion of ceuse of death?

1 Yes 2 No 26. Place of Death (Check only one)

1 Yes 2 No

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) NA

28d. Describe how Injury occurred

29a. Certifier

27. Manner of Death

1 Natural

2 Accident 3 Sulcide

4 Homicide

🗷 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steted 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) and manner stated.

29b. Signature end title of certifier

29c. License number 36112

1 Yes 2 No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print)

72/ HANOVER PIKE HAMPSTEAD, MO 21074 D. ALEXANDER ROCHA mD. 31. Date filed (Month, Day, Year)

State Registrar

SEP 1 0 1997



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

6.6

3. TIME OF DEATH

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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| | DENTON GO | 5. SEX 8. AG | HLER E (In yrs. lest birthday) | IF UNDER | 1 YEAR | IF UNDER 24 HRS. | SEV | | 7 199 | 7 9 | 8. 25A ACE (State or Foreign | |
|---------------|--|--|--|--|--------------------------|---|--------------|----------------------------|---------------------------|----------------|--|--|
| | 22 0094591 90. FACILITY NAME (If not institution, give | 1 M 2 F | 83 YRS. | MONTHS Sh. CITY | DAYS TOWN O | HOURS MIN. | 11- | Day, Year) | | Country) | ud. | |
| ECTOR | RESIDENCE OF DECEDENT | neral Hospi | Deloc | | | ninste | | | Car | | | |
| DIR | Md . COUNTY COUN | uroll | | Fink. | sburg | 3 | | | | 1 | d. INSIDE CITY LIMITS? | |
| VERAL | 3003 Old Westm | inster Pike | | | | 21048 | | | | OF WHA | T COUNTRY? | |
| D BY FUN | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 YES | S 2 XNO | | If yes, spe | ENDENT OF HISPA city Cuben, Mexico 2 XNO Specia | en, Puerlo R | ? (Specify Yellican, etc.) | e or No— 14. | Black, W | American Indian, thile, atc. White | |
| 1 | 15. DECEDENT'S ED (Specify only highest green (0-12) 5th | DUCATION de completed) College (1-4 or 5+) | 16a. DECEDENT'S (Give kind of life. Do NOT | work done ise retired.) | during mos | N t of working | | | Gout. | FRY | | |
| BE COMPLET | 17. FATHER'S NAME (First, Middle, Linst) Charles Albert | Uhler | | 18. MOTHER'S NAME (First, Middle, Melden Surneme) Susie Ann Flynn | | | | | | | | |
| 2 | 190. INFORMANT'S NAME (Type/Print) Charles D. Uhler | L | | | | d Number or Aural Eminster | | | | | . 21048 | |
| | Charles D. Uhler 3110 Old Westminster Pike Finksburg, 20e. METHOD OF DISPOSITION 1 Burdal 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE Of DISPOSITION (Name of competer), crematory or other place) Carroll Cremation 9-9-97 Hampstead, | | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 11824 Reisterstown. Eline Funeral Home Reisterstown. | | | | | | | | | | | |
| CERTIFICATION | IMMEDIATE CAUSE (Finel disease or condition resulting in desth) Sequentially list conditions, lif any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS | A CONSEQUENCE C | PF): | | 16-5 | Q UA | MOL | 18 | | Onset and De | |
| | PART II. Other significent condition. D) ABETES | ons contributing to deeth | but not reculting | t not resulting in the underlying couse given in | | | | | AUTOPSY RMED? 2 DV0 | AM CO OF | RE AUTOPSY FINDIN ALABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO | |
| PHYSICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 10 | HOSPITAL: | rtpetient 3 DOA | OTHER 4 Num | 1: | S G Residence | | | | | | |
| ВУ РНУ | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | | IN. | E OF SURY M | 28c. INJU WOR 1 YE | RY AT | 26d. DESC | CRIBE HOW I | INJURY OCCURE | | | |
| COMPLETED | | SICIAN: To the beat of my kno | wiedge, death occun | ed at the ti | me, date e | | City of | r Town, State) | nner ee stated. | | | |
| TO BE CO | 296. SIGNATURE AND TITLE OF CERTIFIE ARTHUR L, A | WDG, ND' | ATTONDI | NG. | | ath occured at the 29c. LICENSE NUI | | and place, an | 29d. DATE SIC | | | |
| | 30. NAME AND ADDRESS OF PERSON W 31. DATE FILED (Month, Day, Yeer) | DU RO, MS | 904 W | Print) | WE | 6900 | PD (| NES | 2 were | 181 | RMI | |
| | SEP 1 0 1997 | Julia Davidson | Pandelle | | | | | | | | | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

2. DATE OF DEATH MONTH SEPT

9724900999 UNIT # 10-12-46

HULEP, DENTON REORGE

160-A PUDO, ARTHUR L

11/21/1913 M 09/06/97

State of Maryland / Department of Health and Mental Hygiene

27457 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Month Yeer **Physician** JOHN WILLIAMS September 1992 10:28 pin /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Samaritan TOSPITOR Good N/AIf Under 1 Yeer 5. Social Security Number 9. Birthplece (State or Foreign Country)
S. Carolina 7. Age (In yrs. last birthday) **Funeral** 1₺ M 2□ F Deys 247-12-8864 86 Yrs. S. Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at MD N/ABaltimore Director 1. Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with 21206 6000 Belair Road U.S.A. Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes Z Z No If Yes, Give Yeer or Detes: 14. Race - American Indien, Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Bleck, White, etc. filed within 72 hours after 1 Never Merried 2 Married 21215-0020 1 Yes 2 No Specify: Black by 3₺ Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd 2 should be filed within the and Mental Hygiene.
7 is marked out. Elementary/Secondary (0-12) College (1-4or 5+) Construction Foreman 6th other traumetic event. altimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Thomas Williams Rose Watson Pages 1 and 2 should 2 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1639 Bakbury Court, Baltimore, MD 21217 nt of Health e John T. Williams, Jr. 20b. Place of Disposition (Neme of cemetery, grematory or other place)
Mt. Zion Cemetery 20e. Method of Disposition 20c. Location - City or Town, Stete 1 🗷 Buriel 2 □ Cremetion 3 □ Removel from State 6 permit. Page Depertment of Important: If any injury or 9/10 Baltimore, Maryland 5 Other (Specify) 4 Donation 22. Neme end Address of Fecilit LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600LIBERTY HEIGHTS AVENUE, BALTO. 21207 complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel 5 days Sepsis diseese or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner neumonia The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Disease or Injury that Initiated events resulting in deeth) Lest and burial-tran Due to (or es e consequence of): P.O. Box 68760. Physician/Medical the Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Dementia of Vital Records. 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? Completed 24e. Wes en eutopsy Deen page 2 certificate hes 1 Yes 2 No 1 ☐ Yes 2 No or Attending Physician: Be 25. Wes cese referred to medical 26. Piece of Deeth (Check only one) Hospitel: 14⊠ Inpatient 2 □ ER/Outpetient 3 □ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) To 1 Yes 2 No this in by the funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how Injury occurred After t Division 5 Pending Investigation 1 Neturel death. 1 ☐ Yes 2 ☐ No 2 Accident efter death 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours of To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the ceuse(s) and menner es stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated. 29a. Certifier Medical (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) P11403 September mondo Burola MD. 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) NANAKO KURUPA M.D. God Samayston Hospital Stol Lock Roven Blud Baltimise MP 21289 State Registrar

27_H5110-510 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UNKNOWN 97-196 LORETTA M. CHAPMAN Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Deta of Daath Day Month **Physician** MArie TAPMAN SEPTEMBER 8, 1997 06:45 AM /Medical 4a. Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death Examiner SHOCK TRAUMA UNIT BALTIMORE 5. Social Sacurity Number

16 -92 - 909

Usual Residence of Dacadant 7. Aga (In yrs. last birthday).
Yrs. If Undar 1 Year If Under 24 Hrs. Hours Min. **Funeral** 8. Data of Birth (Month, Day, Year) Months Days 1 M 2 F Director 10a State 10b. County 28a-f show 10d. Inside City Limits Yes 2 No Director nAryland 10e. Strae and Numbe 10f. Zip Coda 10g. Citizen of What Country? ö Nerns 23a d Funeral 13. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Evar Armad Forcas? 11. Marital Status American Indian. Black, White, atc. Yas 270 No f Yas, Give Yaar or Datas: 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 'natural', or 1 Yes 2 No Specify: by 3 ☐ Widowad 4 ☐ Divorcad American Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Pages 1 and 2 should be filed withingent of Health and Mental Hygiene.
nt: If tern 27 is marked other than Elamantary/Secondary (0-12) Collega (1-4or 5+) 90 1271 marked other 18. Mothar's Nama (First, Middle, Maide 17. Fathar's Nama (First, Middle, Last) Be ence OMAN 19a. Informant's Name/Ralationship (Type, Print) Cml The, 19b. Mailing Address (Street and Number or Rura Route Number, City or 7211, Department of Health a Important: If Item 27 Is any Injury or other tra 20b. Placa of Disposition (Neme o genetery, crematory or other Mathod of Disposition

1 PBurial 2 □ Cramation 3 □ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funaral Sarvice Licensas 22 Enter the Jisaasa, or complications that causad tha death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Physician Immediate Ceusa (Final disaasa or condition rasulting in death) Wounds of Head Gunshot Due to (or es e consequance of): Examiner Sequantially list conditions, if any, leading to immadiate causa. Entar Undarlying Causa (Disaase or Injury that initiated events rasulting in deeth) Last Due to (or es e consaguance of): Box 68760, the death certificate be Physician/Medicai Due to (or as a consaquance of): P.O. Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Wara autopsy findings availabla prior to completion of causa of death? 24a. Was an autopsy 1 Yas 2□ No 1 Yas 2 No

Completed Be Certification: To

page 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartified completely filled in by the funeral director. Medical

3 Suicide 4 Homicide 29a. Certifier (Check only one)

27. Menner of Deeth

1 Naturel

2 Accident

25. Was case rafarred to medical axaminer?

1 🖾 Yas 2 🗆 No

29b. Signatura and title of certifian

30. Nama and addrass of person

5 Panding Investigation 6 Could not ba dataminad

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 9-9-97 28e. Place of Injury - At hom building, atc. (Specify)

MO

Hospital:

28b. Tima of

At homa, farm, straet, factory, office street

28c. Injury at Work? 1 Yes

OCME

202 No

Othar: 4 Nursing Homa

28d. Describe how injury occurred subject shot

ocation (Street and Number or Rural Route Number, City or Town, State) 1400 Plk School St

SEPTEMBER 8, 1997

5 ☐ Rasidance 6 ☐ Othar (Specify)

1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and mennar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29c. Licansa number 29d. Date signed (Month, Day, Year)

26. Plece of Deeth (Check only one)

tho complated causa of daath (Itam 23a) (Type, Print)

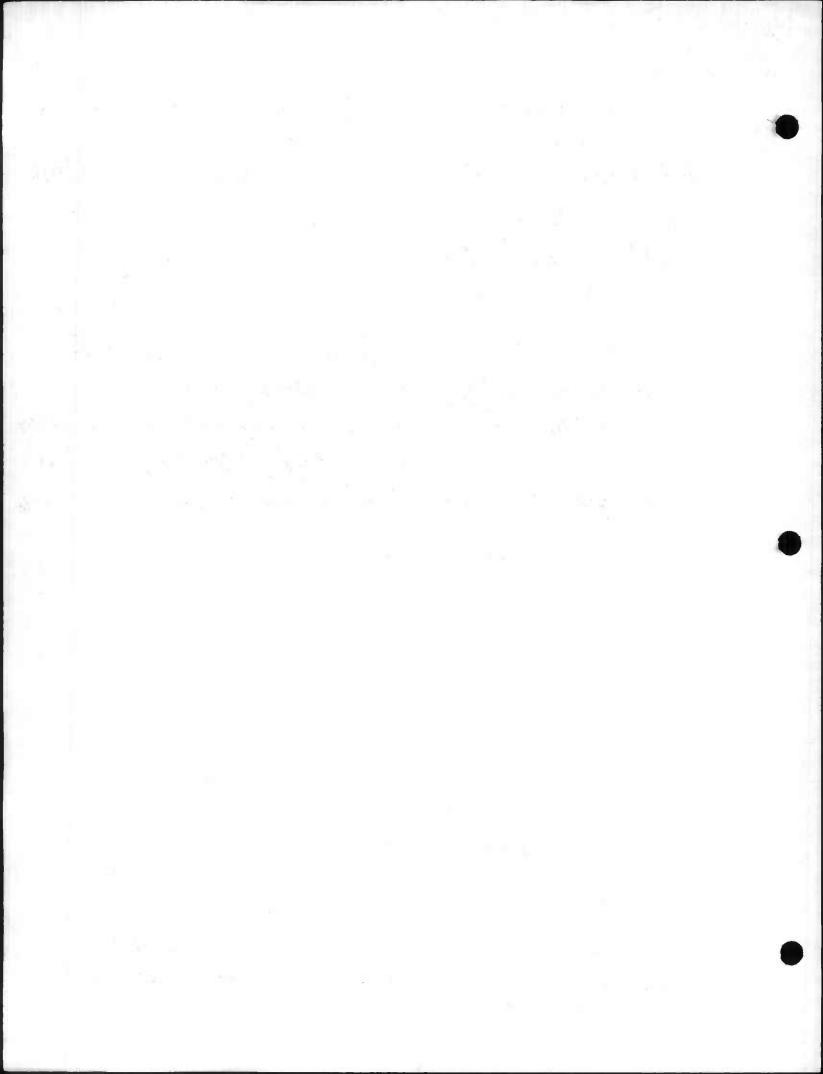
111 Penn Street, Baltimore, Maryland 21201

Venniso 31. Data filad (Month, Day, Year) State

0 199

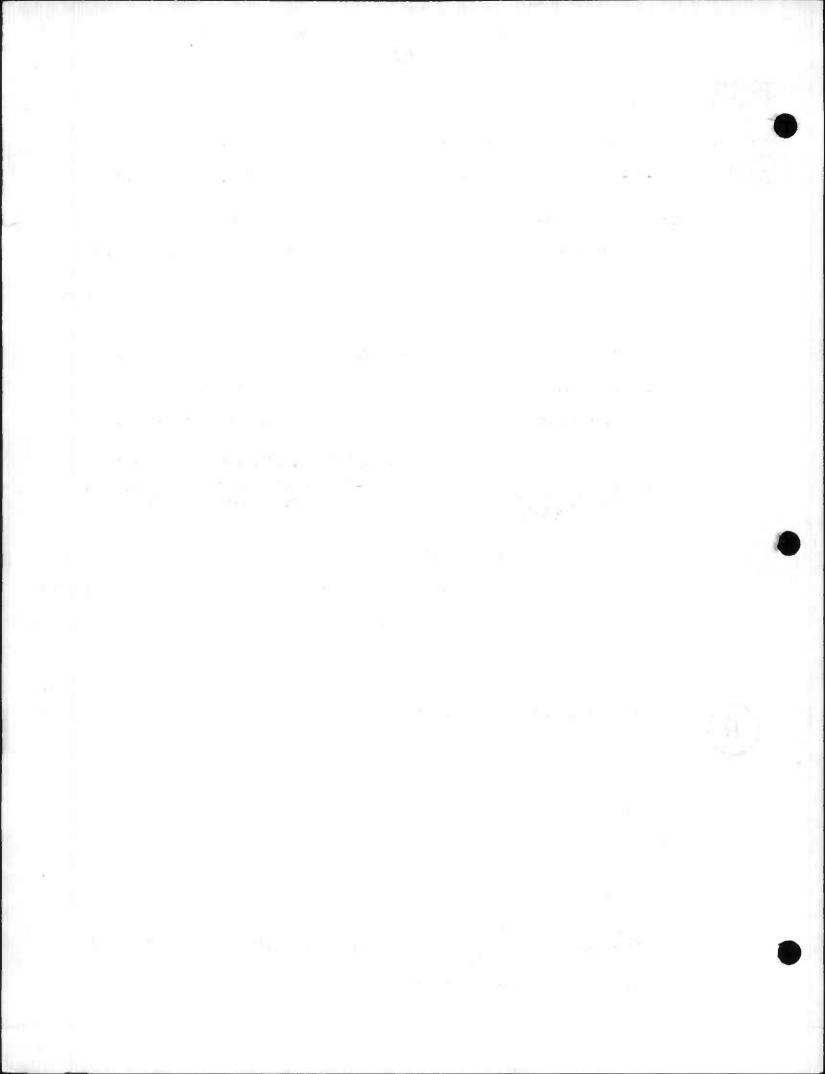
32. Registrar's Signeture ula Davidson

Registrar



| | |] | | tificate of Death | , 0 | iene 97 | 27459 |
|---------------------|---|------------------|---|--|--|--|--|
| | Physic /Medi | | 1. Decedent's Neme (First, Middle, Last) Helen Yost | | 2. Date of Deeth Month | Dey 9 4 | 3. Time of Death 2: 35 pm |
| 1 | Examii Funeral Director | | 4a. Fecility Neme (If not institution, give street and number) Tohns Hopkins Bayview Hosp. 5. Social Security Number 6. Sex 1 M 2 D.F. 90 91 Yrs. | # Under 1 Year Hours Min H | 8. Dete of Birth | 4c. County of Death Year)1906 9. Birth Cou | N/A. piece (State or Foreign intry) yland |
| | yland | | Usuei Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Loc | cation | | | 10d. Inside City Limits |
| | be Mar | ector | Maryland Baltimore | | Dundalk | | 1 ☐ Yes 2 No |
| | 23a or 2 | Funeral Director | 8230 Gray Haven Road | 10f. Zip Coda 21222 | 10 | og. Citizen of Whet Cou United Sta | |
| 020 | 72 hours after death with the Maryland natural', or flerns 23a or 28a-f show dical Examine: must be notified at | þ | 1 Never Merried 2 Merried 1 Yes 2 X No | Vas Decedent of Hispenic Origin? (§ i Yes, specify Cuben, Mexican, Puer □ Yes 2 1 No Specify: | Specify Yes or No- to Rican, etc.) | 14. Race - Amer Bleck, White Specify: | |
| Maryland 21215-0020 | d within giene. r than | Completed | Elemantery/Secondery (0-12) College (1-4015+) | lent's Usuei Occupetion kind of work done during most of wo IO NOT use retired) | orking 1 | 6b. Kind of Business/li Own Hom | 11111 |
| pu | be filed d other | Be | 17. Fether's Name (First, Middle, Last) | 18. Mother's Ne | me (First, Middle, M | feiden Sumeme) | |
| ıryla | d 2 should be filed within and Mental Hygiene. 7 Is marked other than traumatic event, trail. | To | Stanislaus Nitka 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meilin | France g Addrass (Street and Number or R | s Kluczyr | | a Cadal |
| , Ma | 27 F | | | Thorpe Road Pas | | | 122 |
| Baltimore, | o to to | | T Dutier 2 Cremetor 3 Chemove non Stele | sition (Neme of netory or other place) | | 20c. Location - City or T | |
| altin | permit. Pag Depertment Important: I any Injury o | | | of Faith Cem. 9/1 Name and Address of Facility | | Baltimore, | |
| ä | permit. Depertumportum any Inj. | | Potuk M. Hamines | Name and Address of Facility Ouda-Ruck Funeral 1922 Wise Ave. I | Home of Dundalk. N | Dundalk, I Jaruland 2 | nc. 1222 |
| | Physician | | 23a. Psri1. Enter the disease, or detailed that caused the death. Do not ante shock, or heart feilure. List only one cause on each line. | | | | Approximete Intervai Between Onset end Deeth |
| | /Medical Examiner | | resulting in deeth) | neumonia | | | Zniks |
| _ | D # | Iner | Dua to (or as e consequence) Danieta | Λ | | | 2 WKS |
| -6 | ficate be executed physician and is the burial-transit | Examiner | Sequentielly list conditions, the novel leading to immediate | uenca of): | | | |
| 68760, | ysiciar he bun | edicai | cause. Enter Underlying Cause (Disease or Injury thet initiated evants resulting in death) Lest Due to (or es e consequ | | | | 2 WKS |
| | E 50.00 | | d | | | | |
| Box | the attending the attending hed for use 6 | Physician/M | Pert il. Other significant conditions contributing to death but not resulting in the un | derlying cause given in Pert I. | 23b. Did tob | pacco use contribute t | to the cause of death? |
| , P.O. | 1 | Y Ph | critical aortic stenosis | | 1 □ Ye | s 2 No 3□ Pro | bably 4 Unknown |
| of Vital Records, | L | pleted 5 | | | 24e. Wes en | red? | /ara autopsy findings valleble prior to ompletion of cause death? |
| al R | Page 1 | Compl | | | 1 ☐ Yes | s 2 No 1 | □ Yes 2□ No |
| Vit. | Physician: The this certificate rail director, page | To Be | 25. Wes case referred to medical exeminer? 1 ☐ Yes 2 No Hospitel: 1 Inpatiant 2 ☐ ER/Outpetient | Othor | ath (Check only one | | 4. |
| n of | ding Phys h. After this funeral d | | 27. Menner of Deeth 1. Naturel 5 Pending (Month, Dey Year) 28b. Time of Injury | 28c. Injury et Work? | 28d. Describe hov | nca 8 □Other (Speci w injury occurred | (y) |
| Division | | ication | 2 Accident Investigation 3 Suicide 6 Could not be | M 1 Yes 2 No | 29f Loantion (Str. | and and Number of Bu | of Bouto Alimbia |
| Ď. | 7 4 4 5 | Certification: | datarmined datarmined 28a. Pleca of Injury - At home, ferm, stre building, etc. (Spacify) | et, tectory, office | City or Town, | eet e <i>nd N</i> um <i>ber</i> o <i>r Rur</i> State) | er Houre Number, |
| | To the Hospital of within 24 hours at To the Funeral Completely filled in | edical | 29e. Cartiflar (Check only one) MacContiflar Check only one) Check only one) Medical Examiner: On the basis of examinetion end/or invited and menner stated. | occurred et the tima, data and plece estigetion, in my opinion, deeth occu | a, end dua to tha car urred at the time, de | use(s) end mannar as a te end place, and due t | steted. o the ceuse(s) |
| | To the Within To the compl | ¥ | 29b. Signetura end title of cartiflar | 29c. License number | 29 | d. Dete signed (Month, | Dey, Year) |
| | | | · dryon Se | AF2664200H | S | 9-8- | -97 |
| | 25 | | 30. Nema and eddress of berson who completed cause of daath (Itam 23a) (Type, F 440 Eastern Ate. Baltiw | | 21224 | + | |
| | Sta | | 31. Dete filed (Month, Day, Year) 22. Registrer's Signeture | | | | |

DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene

97 27460

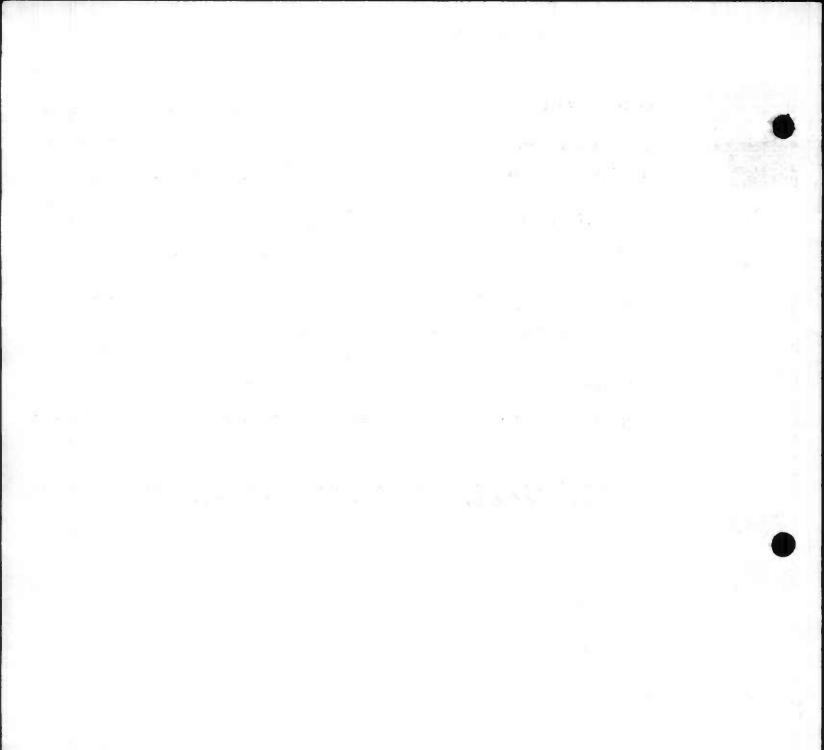
| | | | | | | | Cei | tificate of | f Death | | Reg. No. | | L. 1 400 |
|----------------|--|------------------|--|--|---|----------------------------|---|-------------------------------|--|--------------------|--------------------|-------------------|--|
| | Physic | an | 1. Decedent's Nan | | | | | | | 2. Date of D | | Year | 3. Time of Death |
| | /Medi | | BEVERLY | THERESA | YOUNG | | | | | SEP7 | . 31 | 1997 | 16:52 |
| | Exami | ner | 4a. Facility Name (| | | imber) | | | | r Location of Dea | th 4c. Count | | |
| | | | | ES HOSPIT | | | | | BALTI | | | N/A | A |
| | Funeral | | 5. Social Security f | | Sex 1☐ M 2☑ F | | rs. last birthday). Yrs. | If Under 1 Yaa Months Day: | | | irth lay, Year) | 9. Birthp | place (State or Foreign RYLAND |
| | Director | | 219-38-0 Usual Residence of | | | 56 | 113. | | | JUNE / | ,1941 | MA | KYLAND |
| | wo m | | 10a. State | 10b. County | | 10c. | City, Town or Lo | cation | | | | 1 | 0d. Inside City Limits |
| | Many 1 sh | jo | MD | BALTIN | ORE. | | BAT | LTIMORE | | | | 1 ☐ Yes 2 No | |
| | 28s | Director | 10e. Streef and Nu | | | | | 10f. Zip Coda | | | 10g. Citizen of | nirv? | |
| | 1 end 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. In Trian the Mental Pranting Them 23s or 28s-f show there traumatic event, the Mental Examinat must be notified at | | 2819 GEO | ORGIA AVE | ENUE | | | 2 | 1227 | | | U.S.A | |
| | deati | Funeral | 11. Marital Status | | 12. Was Dec | edent Evar in | U,S. 13. | Vas Dacedent of | Hispanic Orlgin? (ban, Mexican, Pue | Specify Yes or N | o- 14. Ra | ca - Amaric | |
| 0 | after or its | | 1 🗌 Never Man | ried 2 🗓 Married | Armed Fo | 2 MNo | | | | erto Rican, etc.) | Bla | ck, White, | etc. |
| 00 | rai', | l by | 3 🗆 Widowed | 4 Divorced | If Yes, Gi Year or D | ve lates: | | I□Yes 2□XNo | Specify: | | Specif | WH | ITE |
| 21215-0020 | 72 h natu | Completed | (Spe | 15. Decedent's | Education rade completed) | | 16e. Deced | lent's Usuel Occi | upation e during most of w | orkina | 16b. Kind of B | usiness/inc | dustry |
| 121 | ne de la la la la la la la la la la la la la | ign | Elemantary/Secondary (0-12) College (1-4or 5+) | | | | | | red) | | 1101 | (T) (A 7 F | TNO |
| | her ti | | 10TH GRA | | M1 | | HOME | MAKER | 100 100 100 | //** | | MEMAK | ING |
| Maryland | tall had a | Be | 17. Father's Neme (First, Middle, Last) THOMAS McDERMOTT | | | | | | | ame (First, Middle | | 10) | |
| 2 | d Me | 2 | THOMAS McDERMOTT ROSALIE BROWN 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Tow | | | | | | | | | | |
| ∑ | d2s th an 7 is r | | | | | A NITA) | | | AVENUE | | | Stete, Zip 212 | |
| | trent of Health a tant: If Itam 27 is | | 20a. Method of Dis | YOUNG, | deon) Ac | | . Placa of Dispo | sition (Name of | | Data | 20c. Location | | |
| 0 | nt of nt of the transfer or or or or or or or or or or or or or | | 1 St Burlal 2 | ☐ Cremation 3 | | State | cemetery, cran | natory or other pl | , | 9/6/97 | | | WII, State |
| Baltimore, | permit. Pag Depertment Important: 1 any injury c | | 4 ☐ Donation 21. Signature of Fi | 5 Other (Spec | | -/ | - P | | EMETERY | 9/0/9/ | BALTIM | JKE | |
| Ba | permit. F Depertme Importar any injur | | | A PROPERTY ICE LICE | SIISON X | 1/2 | S H | Name and Add | UNERAL H | OME INC. | | | |
| _ | | | () | leusc | 211 | - Chy | 1 4 | 107 WILK | ENS AVEN | UE-BALTI | MORE, M | D 2 | 1229 |
| | | | anock, or hea | the disease, or col art feilure. List onl | mplications that on y one cause on e | aused he de each line. | eath Do not ente | er the mode of dy | Ing, such as cardi | ac or respiratory | arrest, | i | Approximate Interval Between |
| | Physician /Medical | _ | Immediate Cause | /Finel | | | | | | | | 1 | Onset and Death |
| | Examiner | | Immediate Cause (Finel disease or condition resulting in death) e. Intracerebra (hemorr hage | | | | | | | | | | 6 hours |
| 0 | | ē | | | ٨ | | o (or es e conseq | | | | | | |
| 2 | one di na la la la la la la la la la la la la la | 듄 | Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Couse (Disease or Injury that initiated events Due to (or as a consequence of): C. Due to (or as a consequence of): | | | | | | | | | | 4 hours |
| 7.0 | exect n and ial-tra | Exa | | | | | | | | | | 1 | |
| J Q / | certificate be executed uding physician and use as the bunial-transit | Medical Examiner | Ceuse (Disease or that initiated events | Injury | c | Due te | (00000000000000000000000000000000000000 | | | | | | |
| 89 | ificati g phy as the | 8 | resulting in death) Last Dua to (or as a consequenca of): | | | | | | | | | | |
| 30 X | 2 5 8 | | | | l d | | | | | | | | |
| +0 | uires that the death ce is signed by the ettendial | Physician/ | Part II. Other signif | licant conditions | contributing to de | eath but not r | regulting in the ur | ideduina cause o | iven in Dart I | 23h Did | I tobacco use no | ntribute to | the cause of death? |
| 0 | t the de by the teched | hys | , art ii. Other eight | noun conordans | contributing to di | satir but not n | esulting in the di | idenying cause g | iven in Part I. | | Yes 2 No | 3 Prot | |
| J's | gned be de | by P | hone | _ | | | | | | | 1.00 1.01 | 0 | 20.1. |
| Pro | a signal | | | | | | | | | 24a. Wa | s an autopsy | 24b. We | ere autopsy tindings allable prior to |
| 200 | N S S S S S S S S S S S S S S S S S S S | Completed | | | | | | | | pen | ormed? | cor | mpletion of cause deeth? |
| 77 % | halaw for his | EO | | | | | | | | 1 | Yes 2 No | 10 | Yes 2 No |
| ⇒ ita | 100 | Bec | 25. Wes case refer | red to medical | | | | | 26. Place of De | eath (Check only | | | 2.00 |
| 1112 | Physicians: this certific | ToE | examiner? 1 ☐ Yes 2 🔀 | No | Hospital: | Inpatient 2 | ☐ ER/Outpatien | 3 DOA | ther | Home 5 ☐ Res | | er (Specifi | v) |
| 000 | Affer th funeral | Ë | 27. Manner of Deet | | | of Injury th, Day Year) | | 28c. Inj | | | how Injury occur | | |
| 0 0 | | Certification: | 1 Neturel 2 Accident | 5 Pending Investigation | on | ,, | ,u,u, | | Yes 2□No | | | | |
| ME: | or Attances after deatl | tific | 3 Suicide 4 Homicide | 6 Could not determine | 4 289, Placa | of injury - At | t home, farm, stre | et, factory, office | | 28f. Location | (Straet and Numl | er or Rura | Route Number, |
| NAME: Divis | rs afte ai Dir | Cer | | | | 9 (0) | | | | | | | |
| N | To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by | edical | 29a. Certifier (Check only | Certifying P | hyaician: To the | best of my ki | nowledge, death | occurred at the t | time, date and place opinion, death occ | ca, and due to the | ceuse(s) and mo | end due to | ated. |
| | the F nin 24 the F | ed | one) | | and men | ner stated. | | | | ALIAN BITTE OF THE | , dete and place, | unu due (0 | 110 vausa(s) |
| | To To | Σ | 29b. Signature and | title of certifiar | | | | | nsa number | | 29d. Data signa | d (Month, I | Day, Year) |
| | A | | 13 | _ (- | | DD | | 710 | 1880 | | September | +3 | 1997 |
| 7. | | | 30. Neme end add | of person who | completed caus | e of death (It | tem 23e) (Type, I | | | | | | |
| 16 | | | Barry | Liberoni | MD-90 | Caton | Ave | Balturger | e md. | 21229 | | | |

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death ITEM: 23 per DR. G-751 9-11-97 eoh 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Vest Violet E. Adams 9 1997 4:00 PM /Medical Aug. 4a. Facility Name (If not institution, give street and number) 49 County of Death 4b. City. Town, or Location of Death Examiner HRUNDEL 535 Cleveland Road Linthicum If Under 1 Year If Under 24 Hrs. | Months Days Houra Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** 1 M 2 F Days 219-16-7729 Yes Director 80 April 10, 1917 Ohio Usual Residence of Decedent the Maryland 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits 7 is merked other than "natural", or items 23s or 28s-f shov traumetic event, the Medical Examiner must be notified as 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with U.S.A. Funeral 12. Was Decedent Ever in U,S Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritai Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If them 27 is merked other than "natural", or then any Injury or other traumetic avane. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 N Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify. Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'a Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Travis George Lee Cencia Yates 20 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. informent'a Neme/Relationship (Type, Print) Shirley Houk, daughter 535 Cleveland Road, Linthicum, Maryland 21090-2803 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donatton 5 □ Other (Specify) 22, Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street nerai Service Licensee Ronald S. Wade / Director Baltimore, Maryland 21201

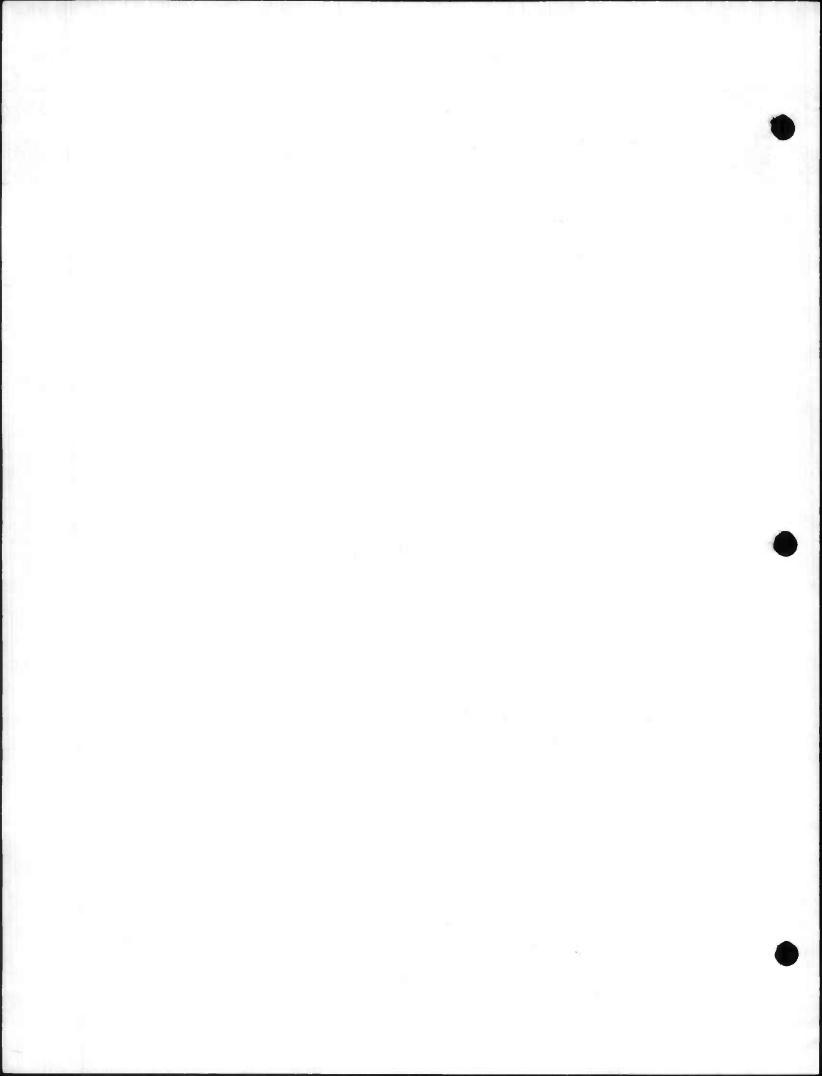
23a Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical immediate Cause (Finat disease or condition resulting in death) Examiner Examiner ician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician sthe burial Box 68760 Physician/Medical Due to (or as a consequence of) use for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. the signed by t 1 Yes 2 No 3 Probably 412 Unknown by 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? Completed peen s has page 2 certificata 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 28. Piace of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) this funeral Date of injury (Month, Day Year) ve Hospital or Attending Ph n 24 hours after death. Ne Funeral Director: After th 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 WNetural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Ptaca of Injury - At home, ferm, street, factory, offica building, etc. (Specify) filled in by 4 - Homicide 29a. Certifle Medical 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. pletaly (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cauae(s) and manner stated. To the To the To the F 29b, Signature and title of certifie 29d. Date signed (Month, Day, Year) ame who completed cause of d SAMIREZ 1. 32 Pegistrar's Signatura La Nevidson-Randell

State Registra



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | | | | | Certific | ate of | Death | | F | Reg. No. | | | |
|---------------------|--|----------------|---|--|------------------------------|---|----------------------------|---|-----------------------|----------------------------------|-----------------------------------|----------------------------|---|----------------|
| | | | 1. Decedent's Name (First, Middle, La | | | | 2. Data of Dea | ith | | 3. Time of | f Death | | | |
| | Physic | | Kather | ine Wisner | В1 | adsh | aw | | | SEPT. | $6^{\text{pay}}, 19$ | 97 | 1:0 | Oam |
| 3 | /Medi Examlı | | 4a. Facility Name (If not Institution, giv | | | | | 4b. City, To | wn, or L | ocation of Death | | | | |
| 1 | Exami | iei | Solomons Nurs | | | | | Solo | mon | ıs | | lver | t | |
| | Funeral | | Social Security Number 6. S | Sex 7. Aga (In yr | | hday) If Un Mont | nder 1 Year | If Under Hours | 24 Hrs. Min. | 8. Date of Birth | Year | 9. Birthpl | lace (State o | or Foreign |
| Ġ. | Director | | 579-30-1520 | 10 M 201 F 89 |) 1 | rs. | lis Days | 110013 | Will. | MARCH I | 7, 1908 | Vi | rgin | ia |
| | pu * | | Usual Rasidence of Decedent 10a. State 10b. County | 100 (| Tity Tourn | or Location | | | | | | 14 | Od fooids O | in a t tomit o |
| | aryle sho | - | | | sity, Town | | | | | | | " | 0d. fnside C | |
| | Ne M | Director | Maryland Calv | ert | | - | olom | ons | | 1 | | | | 2 No X No |
| | vith th | Ē | 10e. Street and Number | D 1 | | 10f. | Zip Code | 20606 | ` | 1 | 10g. Citizen of What Country? USA | | | |
| | ath v | ia. | 13325 Dowell | | | 20688 S. 13. Was Decedent of Hispanic Origin? (Specify Y if Yes, specify Cuban, Mexican, Puerto Rican, | | | | | | | | |
| | er de | Funeral | 11. Marital Status | 12. Was Decedent Ever in Armed Forcas? | U,S. | 13. Was De | ecedent of the specify Cub | lispanic Ori an, Mexicar | gin? (Sp 1, Puarto | ecify Yes or No- Rican, atc.) | 14. Raci | e - Amarica k, White, e | | |
| 020 | Mr. or | by F | 1 ☐ Navar Marriad 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 Yes 2 No If Yes, Give Year or Dates: | | 1 ☐ Yes 2 No Specify: | | | | | Specity | Wh | nite | |
| Maryland 21215-0020 | filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Itama 23a or 28a4 show ont, the Medical Examinat must be notlined at | Completed | 15. Decedent's Ed (Specify only highest gra | ducation | 16a. | Decedant's L (Give kind of | Isual Occup | oation during mos | t of work | ina | 16b. Kind of Bu | siness/Ind | ustry | |
| 121 | within ene. than | jdu | Elementary/Secondary (0-12) | Collega (1-4or 5+) | | (Give kind of work done during most of work life. DO NOT use retired) Housewife | | | | | D | E | | |
| 2 | e filed withing the filed withing the filed within the filed went, the filed went, the filed went, the filed within the filed | | 8 | | | nouse | wile | 40.31.45 | de Alexan | - (Fi)) (- d-d- | Dome | | - | |
| and | d sal | Be | 17. Fathar's Nama (First, Middle, Last) James Edward | | | | | 18. Mother's Name (First, Middle, Maiden Surname Emma Lee Anderso | | | | | | |
| 3 | ges 1 end 2 should be it of Health and Mental If item 27 is marked o or other traumatic eve | To | | | T | | | | | | | | | |
| Ma | 12 sho h and h sm r is me | | 19a. Informant's Name/Relationship (| | 190. | - | | | | ral Route Numbe | | State, Zip | Coda) | |
| | f Health itam 27 I | | Tom Wisner/son | 20h | Place of | Box Disposition (| / C | alifo | orni | a, MD | 20619 20c. Location - | City or To | um State | |
| 20 | M ite | | 1 ☐ Burial 2 ☐ Cremation 3 ☐ | IHAMOVALITOM STATA | - | Disposition (| | | h | | | | | , |
| Baltimore, | t. Pertant | | 4 Donation 5 Other (Specif | | tro | Cremato | | | 1 | /6/97 | Balti | more | , MD | ' |
| Ba | permit. Peges Department of Himportant: If its any injury or of once. | | 21. Signatura of Fonarai Service Ligar | 7000 lma 1 1 | | 0 | | n Socialis | | v of M | iarvlar | d. | Inc. | |
| | | | Cremation Society of Maryland, Inc. Dawn F. McDonald 299 Frederick Road Baltimore, MD 2122 23a. Panl. Enlar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, interval Between Onset and Development of the mode of dying. | | | | | | | | | | | |
| U | • | | 23a. Part1. Entar the disaase, or com shock, or heart failura. List only | plications that caused the da one cause on each line. | ath. Do n | ot enter the r | node of dyi | ng, such as | cardiac | or raspiratory ari | rast, | 1 | Approximat Interval Bet Onsat and | ween |
| | Physician /Medical | | | | | | | | | | | | Oriodi dila | Death |
| | Examiner | | Immediate Cause (Final disease or condition resulting in death) a. Anokals/e shake | | | | | | | | | | | |
| | 7 10 10 | ē | | Due to | (or as e c | onsaquence | of): | | | | | i | | |
| | onsit | Examiner | | b. Due to | /01 00 0 0 | onsequenca | a6): | | | | | | | |
| ć | exec In an iel-tr | Exa | Sequantially list conditions, if any, leading to immediate cause. Enter Undarlying | Due to | (OI as a C | onsequenca | 01). | | | | | | | |
| 68760, | ysicia be bu | edicai | that initiated events | c. Due to | to (or as a consequence of): | | | | | | | | | |
| 89 | eath certificete be executed ettending physician and for use as the buriel-trensit | Med | resulting In death) Last | | , | · | , | | | | | i | | |
| Box | th ce tendii | an | | d | | | | | | | | 1 | | |
| 0. | the etter the otter hed for u | Physician | Part II. Other significant conditions of | ontributing to death but not re | asulting in | tha undarlyir | ng causa gi | van in Part I | | 23b. Did to | obacco use cor | tributa to | the cause | of death? |
| Ρ. | = 50 | | history of E | trales los | LADI | teuss | CH. | | | 1 🗆 Y | /es 2□No | 3 Prob | ably 4 | Minknown |
| ds, | 8 .5 eq | l by | history of a | 19 | 1.00 | | | | | | | 0.4h 14/a | | Ata etin |
| 0 | v requires been sign should be | etec | atrial tob | rellaBai | | | | | | 24a. Was a perfor | med? | ava | era autopsy i ailable prior i apletion of c | to |
| Records, | 2 8 8 | Completed | | | | | | | | | | of c | death? | |
| = | Page Page | | | | | | | | | 1 🗆 Y | es 20No | 1 🗆 | Yes 2 | No |
| Vital | Physician: The this certificate ral director, page | Be | 25. Was casa rafarred to medical examinar? | Hamitali | | | l Oil | | of Deal | h (Check only or | ne) | | | |
| of | Physic this or | T | 1 Yes 2 No | | □ ER/Out | | DOA | | irsing Ho | ome 5 Resid | | | 9 | |
| | | lon: | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day Year) | 28b. Ti | jury | 28c. Inju Wo | | A1. | 28d. Dascribe h | ow injury occurr | 90 | | |
| Sign | Attending ir death. actor: After by the fune | icat | 2 Accident investigation 3 Suicide 6 Could not be | 9 | h | M | | Yes 2 | NO | 28f. Location (S | Street and Mumb | or or Pum | I Doute Mun | phor |
| Division | o age ⊑ | Certification: | 4 ☐ Homicide datermined | 28e. Placa of Injury - At building, etc. (Spec | noma, ran | m, street, tac | nory, omca | | | City or Tow | | er or nura. | House Man | iber, |
| | Hospital or Att 24 hours after d Funeral Direct | | 29a. Certifier 1 Certifying Ph | vsfcfan: To the best of mv kr | nowledga. | daath occur | red at tha ti | ma, data an | d place. | and dua to the o | causa(s) and ma | nner as st | ated. | |
| | 29a. Certifier (Check only one) 29a. Certifier 29a | | | | | | tlon, in my o | pinlon, dea | th occur | red at the time, o | date and place, a | and dua to | tha causa(s | s) |
| | To the within | 2) | 29b. Signature and title of certifiar | 1/1/ | | | 29c. Licens | | | | 29d. Date signed | (Month, I | Day, Yaar) | 11 73 |
| | ([| | 1 Vona | 松书 | V | | 13 | 952 | 5 | | 9/6/ | 97 | | |
| | | 1 | 30. Name and address of person who | completed cause of death (Ite | em 23a) (| Type, Print) | | | | | 000 | | | |
| _ | | | 120 Hospital | Ad. Prov | ce. | Type, Print) | lend | Zo No | 11 | 200 | 5×6 | | | |
| | Sta Registr | | SEP 1 1 1007 | 32. Registrar's Sig | nature | and DO | | | _ | | | | | |



State of Maryland / Department of Health and Mental Hygiene

| | | | | | | Certifica | ate of | Death | | Reg. | No. |) [| 21403 | |
|----------------------------|---|--|---|---|-----------------------|--|-----------------------------|--------------------------------------|--|------------------|-----------------------------|--------------------------|---|--|
| ľ | Physic /Medi | | 1. Decedant's Nama (First, Middle, Las Willtam Baylo | * | | | | | 2. Dafa of Do Month | Ab- | Day 97 | Year | 3. Time of Death | |
| | Exami | | 4a. Facility Nama (If not Institution, give Bal Homens VA M | | | | 4 | Baltin | or Location of Dea | | 4c. County | of Death | e. | |
| | Funeral Director | | | | (In yrs. last 84 | birthday) If Unc Yrs. Month | lar 1 Yaar s Days | If Undar 24 H Hours M | 8. Dafa of Bi in. (Month, D 08-22- | irth ay, Ye | ear) | Coun | leca (Stata or Foreign try) INIA | |
| | and | | Usual Residence of Dacedant 10a. Stata 10b. County | | 10c, City, To | own or Location | | | | | | 1 | 0d. Inside City Limits | |
| | f sho | 5 | MD. N/A | | | IMORE | | | | | | | 1 ∑ Yea 2 □ No | |
| | the 128s | Director | 10e. Streef and Number | | | | Zip Code | | | 10a. | Citizen of V | Vhat Coun | itry? | |
| | 3a or | | 2469 BRENTWOOD A | VENUE | | | 21218 | 3 | | | USA | | | |
| Maryland 21215-0020 | 72 hours after death with the Maryland netural, or thems 23a or 28a-f show dical Examiner must be notified at | by Funeral | 11. Marital Stafus 1 Nevar Married 2 (Married 3 Widowed 4 Divorced | 12. Was Decedent E Armed Forcas? 1∑ Yes 2 □ No If Yas, Giva Yaar or Datas:4 | 0 | | | | (Specify Yes or N arto Rican, etc.) | | | | CIAN | |
| 50 | n 72 hours "netural", edical Ex | ted | 15. Decedant's Edu (Specify only highast gred | ication | 10 | Sa. Decedant's Us | uai Occup | ation | und Inc | | . Kind of Bu | | | |
| 2 | C * 49 | Completed | Eiemantary/Secondary (0-12) | Coilege (1-4or 5- | | | | during most of v | working | | NITAT | - | | |
| 2 | | | 11 | 0 | S | SANITATIO | ON MOL | | | 1 | LTIMO | | 1 Y | |
| and | 8 1 9 9 | Be | 17. Fathar's Nama (First, Middle, Last) WILLIAM BAYLOR | | | | | | lama (First, Middle | | den Sumam | a) | | |
| Z | d 2 should be th and Mental 7 Is marked or traumetic eve | 70 | 19a. Informant's Neme/Relationship (T | na Printi | | Ob. 184-195 4 -4 | (0) | | IA TAYLOR | | | O T- | 0-11 | |
| Ma | 2 t 2 e | | QUEEN BAYLOR | ype, Print) | ' | | | | BALTIMO | | | | | |
| | - F E E | | 20a. Mathod of Disposition | | 20b. Piaca | of Disposition (A | ama of | | DALTINUI | _ | Location - | | | |
| Baltimore, | age ent c rt: # y or | | 1 XBuriai 2 Cramation 3 1 4 Donation 5 Offer (Specify, | | | RISON FOR | REST | | 9-9-97 | | INGS 1 | | | |
| Ba | permit. F Departmo Importan any injur | | 21. Signature of Funeral Service Licens | ils | tup | z EST | TEP BI | | FUNERAL BALTIMON | | | 21217 | | |
| п | | | 23a. Part1. Entar tha disease, or comp shock, or heart failura. List only o | lications that caused in na causa on each line | the daath. D | o not antar tha m | oda of dyin | g, such as card | liac or raspiratory | arrest, | | | Approximsta Intarvai Between | |
| P | Physician /Medical Examiner | | Immediate Causa (Final diseasa or condition rasulting in death) Onset and 3 day | | | | | | | | | | | |
| п | | - | rasulting in death) | | | a consequance o | f): | | | | | 1 | | |
| 68760, | certificata be axecuted ding physician and usa as the bunal-transit | edical Examiner | | | | | | | | | | | | |
| Box 6 | nding usa a | Σ | · | d | | | | | | | | | | |
| 0 | e death the atter | by Physician/ | Part II. Other significant conditions co | ntributing to death but | nof resulting | g in the underlying | cause giv | en in Part I. | 23b. Did | tobac | cco use co | ntributs to | the cause of death? | |
| P.O. | that the ned by the | Æ | multiple onsa | n syste. | n f | ailure | | | 1□ | Yes | 200 No | 3 Prot | bably 4 Unknow | |
| Division of Vital Records, | v requiras been sign should be | Completed by | | | | | | | 24a. Wa: | s an s | | ave | ara autopsy findings allable prior to mplation of cause death? | |
| æ | Tha law ta has | mo | | | | | | | 10 | Yas | 2 No | 10 | Yes 2□ No | |
| ā | delan: Thu cartificata irector, pag | Be C | 25. Was casa raferred to medical | | | | | 28. Placa of D | Death (Check only | ona) | | | | |
| <u>></u> | Physician: this cartific tral director, | To | examinar? 1 ☐ Yas 2x No | lospitai: Inpatian | t 2 ER/ | Outpatient 3 1 | DOA Oth | ne: | Homa 5□ Ras | | 8 🗆 Oth | ar (Specif) | v) | |
| ion o | il or Attending Pt aftar death. I Director: Aftar th d in by the funaral | | 27. Menner of Death Natural 5 Panding 2 Accidant invastigation | 28a. Data of tnjun (Month, Day | Year) 28t | o. Tima of Injury M | 28c. Injun Worl | yat k? Yas 2∐No | 28d. Describe | how i | njury occuri | red | | |
| Divis | al or Atte | 28a. Data of thjury 28b. Tima of Injury at Work? Standard Sta | | | | | | | 28f. Location City or To | (Strea own, S | t an <i>d Numb</i> tata) | er or Rura | I Routa Number, | |
| | To the Hospital or Attending Physicien: The lew within 24 hours after death. To the Funeral Director: After this cardificate has completely filled in by the funeral director, page 2 | edicai | 29a. Certifiar (Check only one) 2 Medical Exami | sician: To the best of ner: On the basis of a and manner state | examination. | lga, daath occurre and/or invastigation | d at the fin on, in my o | na, deta and pts pinion, daath oc | aca, and dua to the ocurred at tha tima | caus , data | a(s) and ma and place, | nnar ss st and dua to | tated. the cause(s) | |
| | To the To the Comit | Ž | 29b. Signature and fifie of certifus | 7 | | | 9c. Licans | | | | Data signa | | Day, Year) | |
| | 1. | | June & | An mo | | | P102 | 48 | | < | 9/3/9 | 7 | | |
| | D | | 30. Nama and series of person who co | mo 22 | 2. (| brache S | t. | Balti | more, n | O | 2111 | , | | |
| ľ | Sta Registr | | 31. Date filed (Month, Day, Yeer) SEP 1 1 1997 | File Da | g grature (d.sov – | fandelle | | | | | | | | |

Registrar

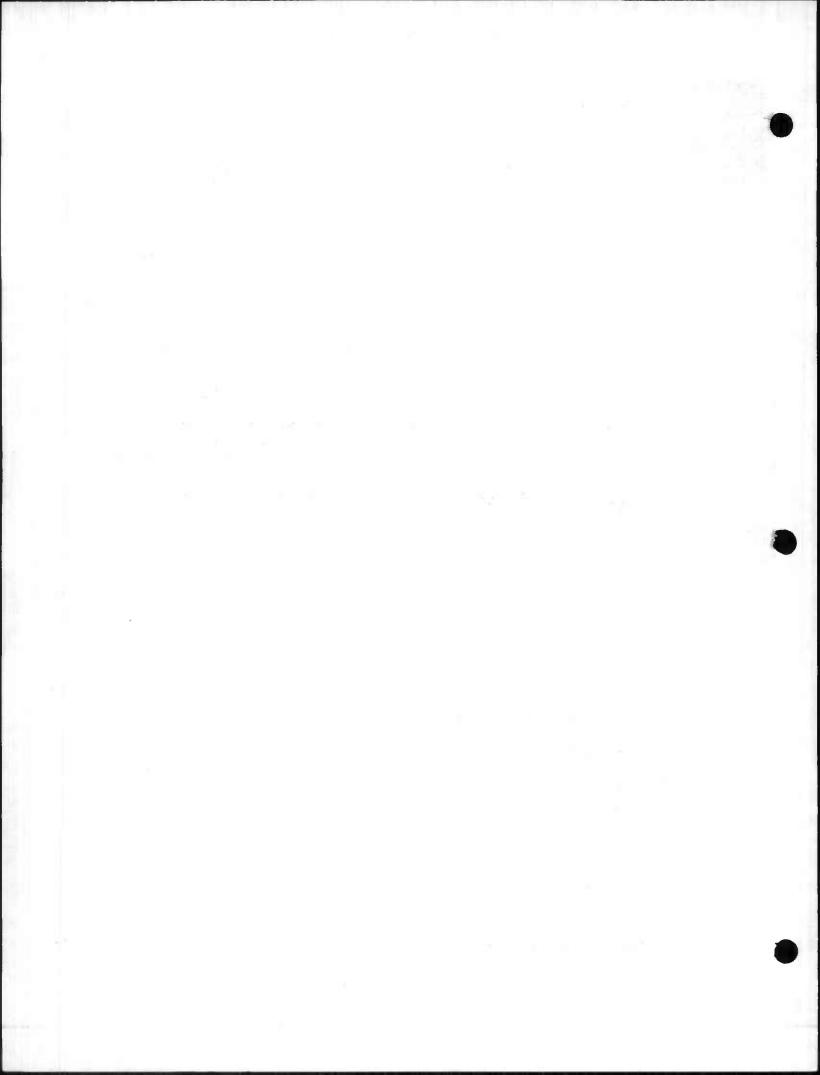
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State of Maryland / Department of Health and Mental Hygiene 9 7

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| | | | | | Ce | rtifica | ate of | Death | | Reg. No. | 21 | 41707 | |
|--|--|------------------------|---|---|-----------------------------------|---|-------------------------|-------------------------------------|---|--|--|---|--|
| Physicia: /Medica | | ion | 1. Decedent's Neme (First, Middle, La | | | | | | 2. Data of Deeth Month Dey | | 3. Time of Deeth | | |
| | | | EUIC L. OIUVVI | | | | | | 9 | 2 | 97 | 15:10 | |
| | Exami | ner | 4a. Facility Neme (If not institution, give street and number) Johns Hopkins Bounew Med Ct | | | | | 4b. City, Town, or | | | 4c. County of Deeth | | |
| | | | | | Baltimo | | | | re Baltimore city | | 2 City | | |
| | Funeral Director | | 5. Social Security Number 212 - 28 - 4079 Usual Residence of Decedant | s. last birthday) Yrs. | | If Under 1 Year If Under 24 Hrs. Min. 8. Data of Months Deys Hours Min. | | | Birth Dey, Year) 9. Birthplace (State or Foreign Country) | | | | |
| nd 21215-0020 | New M | | 10a. Stete 10b. County | 10c. (| City, Town or Lo | | | | | | | 10d. Inside City Limits | |
| | be filed within 72 hours after deeth with the Maryland lel Hyglene. I other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be neutried at | tor | MD Baltimore Baltimore 10000 201 | | | | | | | | 1 12 Yes 2 □ No | | |
| | | by Funeral Director | 10a. Street end Number 10to Andover Road 10f. Zip Code 2/2/8 USA | | | | | | | untry? | | | |
| | | | 11. Marital Status 1 Never Married 2 Married 3 Novidowed 4 Divorced | 12. Wes Decedant Evar In Armed Forces? 1 Yes 2 No If Yes, Give Yaar or Dates: | | 13. Was Decedent of Hispanic Origin? (Spe If Yas, specify Cuban, Mexican, Puarto 1 ☐ Yes 2 DNo Specify: | | | Specify Yas or N to Rican, etc.) | | 14. Base - American Indien, Bieck) White, etc. Specify: BLACK | | |
| | n 72 hours "natural", | | 15. Decadant's E | ducation | 18e. Dece | dant's Us | suei Occu | petion | | 16b. Kind | of Businass/I | | |
| | hin 7 | Completed | (Specify only highest gri | 2de completed) Collega (1-4or 5+) | (Give | kind of I DO NOT | vork done use retire | during most of wo ed) | orking | | | | |
| | filed with Hygiene. ort, the Ment, | No. | 12th | lyr | HOU | HOUSEWIFE | | | | HOME | | | |
| | should be filed withind Mentel Hygiene. marked other than | To Be (| 17. Fether's Nema (First, Middle, Last | 18. Mother's N | | | 18. Mother's Ne | eme (First, Middle, Maiden Surnema) | | | | | |
| yla | 2 should be end Mentel is marked or sumatic ever | | EUGENE JOHNSO | N | | | RACHEL UNKNOW | | | WN | NN | | |
| Baltimore, Maryland | 1 end 2 s Health er Im 27 is ther trau | | 19e. Informent's Neme/Reletionship | Type, Print) | 19b. Maiii | ng Addre | ss (Stree | t and Number or R | ural Route Num | ber, City or | Town, State, Z | ip Code) | |
| | | | WEBB F BROWN | 001 | 4037 | | | | ALTO, | | 1215 | | |
| | | | 20e. Method of Disposition 1 □ Buriai 2 □ Cremetion 3 □ | Removel from Stata | cemetery, crei | metory o | r othar ple | sce) S | EPT 9 | 20c. Loca | ation - City or 1 | Town, Stata | |
| | rtmer rtant: | | 4 Donetion 5 Other (Special | | | | | | | | ALTO MD | | |
| | permit. Peges Depertment of I Important: If ite any injury or of | | 21. Signeture of Funeral Service Lice | nsee n | _ | | | ess of FecilityBE | | NERAI | | | |
| | | | Patricia | Bella | 1 | | | CAROLI | | | D, MD | 21213 | |
| | Physician /Medical Examiner | | 23a. Pert f. Entar the disease, or com- shock, or heart feilura. List only | one ceuse on aach line. | ath. Do not ant | ter the m | ode of dy | ing, such es cardia | c or respiretory | errest, | i | Approximete Intervei Between Onsat and Death | |
| | | | Immediate Cause (Final | . 22 7 | | 1- | 0 - | 26 | | | 1 | Orisal and Death | |
| | | | disease or condition resulting in deeth) e. Jespuratoru autus Dua to (or as a gonsequenca of): | | | | | | | | | | |
| | | ē | | Dua to | (or as a donse | prenca o | - 0 | | 1.50= | | | 20 | |
| Division of Vital Records, P.O. Box 68760, | uted d ansit | Examiner | | b. Chronic o | | rive. | | monary | ousea | se | 1 | 20 years | |
| | exec an an riel-tr | Exa | Sequentielly list conditions, if any, leading to Immediate cause. Enter Undarlying Causa (Diseese or Injury | Due to | Due to (or es e consequence off): | | | | | | | | |
| | The law requires that the death certificate be executed ate has been signed by the ettending physician and page 2 should be detached for use as the burlel-transit | edical | that initieted events | C. Due to (or es a consequenca of): | | | | | | | | | |
| | | 2 | | | | | | | | | | | |
| | | clan | | | | | | | | | | | |
| | | Completed by Physician | Pert II. Other significant conditions contributing to death but not resulting in the undarlying cause given | | | | | iven in Pert I. | | | | sacco use contribute to the cause of death? S 2□ No 3☑ Probably 4□ Unknown | |
| | | | Chronic renal y | il unsufficiency, | | | | | 11 | 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown | | | |
| | v requires been sig should b | 중 | | | | | | | | | Vere autopsy findings | | |
| | s been 2 shoul | olet | before | | | | | | | tomed? | evaileble prior to complation of cause of deeth? | | |
| | The law ate hes page 2 | E | anemia | | | | | | 1 | Yes 2 🖭 | No 1 | Yes 20 No | |
| | tending Physician: leeth. for: After this certifica the funeral director, | Be C | 25. Wes casa referred to medical | sa referred to medical 28 Place of Death (Check only one) | | | | | | | | | |
| | | To | exeminer? 1 Yes 2 No | Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) | | | | | | | | oify) | |
| | | Certification: | 27. Manner of Deeth 1 ☑Naturel 5 ☐ Pending | 28e. Deta of Injury 28b. Time of Injury Injury | | | 28c. Inju Wo | ry et ork? | | 8d. Describe how injury occurred | | | |
| | | cat | 2 ☐ Accident investigatio 3 ☐ Suicida 6 ☐ Could not b | | | | | Yas 2 No | | · (0) | | | |
| | or Al | Ŧ | 4 ☐ Homicide determined | 200. Pieca of injury - At nome, ferm, streat, fectory, office 201. Local | | | | | | ation (Street end Number or Rural Routa Number, or Town, State) | | | |
| | To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by | edical Ce | | | | | | | | | | stated. | |
| | the the mplet | Med | one) | | | | | | | | | | |
| | 5 1 5 8V | | 29b. Signeture and title of certifier | 29c. License | | | | | 9d. Dete signed (Month, Dey, Yaar) | | | | |
|), | (1) | | // | | 77030 | | | | September 2,1997 | | | | |
| (| M | | 30. Name and address of person who | completed causa of daath (its | | Print) | 212 | 24 | | | | | |
| | M | 40 | 31. Dete filed (Month, Dey, Yeer) | Waller Bross bross | nore, | 6110 | صدا ط | die [| | | | | |
| | Sta Registr | | SEP 1 1 1997 | Carlin Davidson | - Andell | | | | | | | | |

DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene Items19a,19b 9-15-97 FilmG751 W.H.Per Informant Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death BOSS Month JOHN RANDOLPH SEPTEMBER 9, 1997 04:30AM 4b. City, Town, or Location of Deeth 4c. County of Deeth BALTIMORE CITY if Undar 1 Yaar | if Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthptace (State or Foreign Country) 10 M 2□ F Months Deys Hours 60 Yrs. MAR. 8 1937 MARYLAND 10c. City, Town or Location BALTIMORECO (OWINGS MILLS) 10d. Inside City Limits na 1 Yas 2 TNo 10f. Zip Coda 10g. Citizan of What Country? COURT CIRCLE 21117 UNITED STATES ant Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amaricen Indian, Black, White, atc. 1 ☐ Yas 2☐No Specify: Specify: BLACK

must be nothing at Director Funeral r than "natural", or items the Medical Examiner m Peges 1 and 2 should be liled within 72 hours effer inent of Health and Mental Hygiena. Int: If Item 27 is marked other than "natural", or ite ģ Completed Be other

Physician

/Medical

Examiner

Funeral

Director

death with the Maryland

altimore, Maryland 21215-0020

Physician /Medical **Examiner**

ò permit. Pege Department of Important: If any Injury or once.

that the death certificate be executed bunal-transit pue physician s the bunel 2 signed b peen page 2 s Division of Vital Hospital or Attending Physician: 24 hours eftar deeth. Director

Physician/Medical þ Be 10 Certification: Medical

4a. Facility Name (If not Institution, giva street and number) THE JOHNS HOPKINS HOSPITAL 5. Social Security Number 216-36-9300 Usuel Rasidance of Decedan 10b. County 10e. Street and Number 4507 LYONS RUN 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas X2V No if Yas, Give Year or Datas: 1 ☐ Nevar Merried 2 🂢 Married 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usuat Occupetion (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highest grada completed) Elemantary/Secondary (0-12) Coltaga (1-4or 5+) SECURITY ATTENDANT CLIFTON P. PERKINS 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middla, Maidan Sumame) JOHN ROBERT BOSS CARLYN RANDOLPH 4000 Labyrinth Road Baltimore, MD. 21215 19a. tnformant's Name/Ralationship (Type, Print) 19b. Meiling Address PATRICIA LYONS KUN CINCLEAPTIOS, OWINGS MILL ANN MC DANTERS -4507Bernice Boss (Wife) 20a. Method of Disposition 20b. Placa of Disposition (Nama of camatery, cramatory or other place) 20c. Location - City or Town, Stata Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) KING MEMORIAL. PARK 9-13-97 RANDALLSTOWN, MD 21. Signature of Funaral Sarvice Licensas 22. Name end Addrass of Facility WM C. MARCH FH -4300 WABASH 23a. Part1. Entar the disease, or complications that caused the deeth. Do not anter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete tntarval Batween Onset and Death Dysry thmia Ventricular Thirty minutes Immediate Cause (Final disaasa or condition rasulting in daath) My o Cardial Infarction Two Itours Sequantially list conditions, if any, laading to immediata ceusa. Enter Undarlying Cause (Diseesa or tnjury that initiated evants rasulting in daath) Last Dua to (or as a consequence of) Sixteen Hours Dua to (or es e consequance of): Bleeding Sixteen Hours Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of ceuse of death? 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Wes cese refarred to madical 26. Plece of Death (Check only ona) axaminar? Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Yaar) 27. Menger of Deeth 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 1 Netural 5 Panding Invastigation injury 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28a. Place of tnjury - At homa, farm, street, fectory, office building, atc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) end mannar as stated.

2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and mannar stated. 29a. Cartifiar

29b. Signatura and tuta of certifiar

Alegist, Carron M.D.

29c. Licansa number RES-000

29d. Data signed (Month, Day, Year) September 9, 1997

AVENUE

J. Carrar, mo 600 North Wolfe Street, Johns Hopkins Hoppital, Ballimore, Maryland

State Registrar 31. Dete filed (Month, Day, Year)

SEP 111997

37 Registrars Signature

Funeral

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. FilmG751 W.H.per F/H

State of Maryland / Department of Health and Mental Hygiene

ITEM: 7,8 per FH G-751 9-16-97 eoh

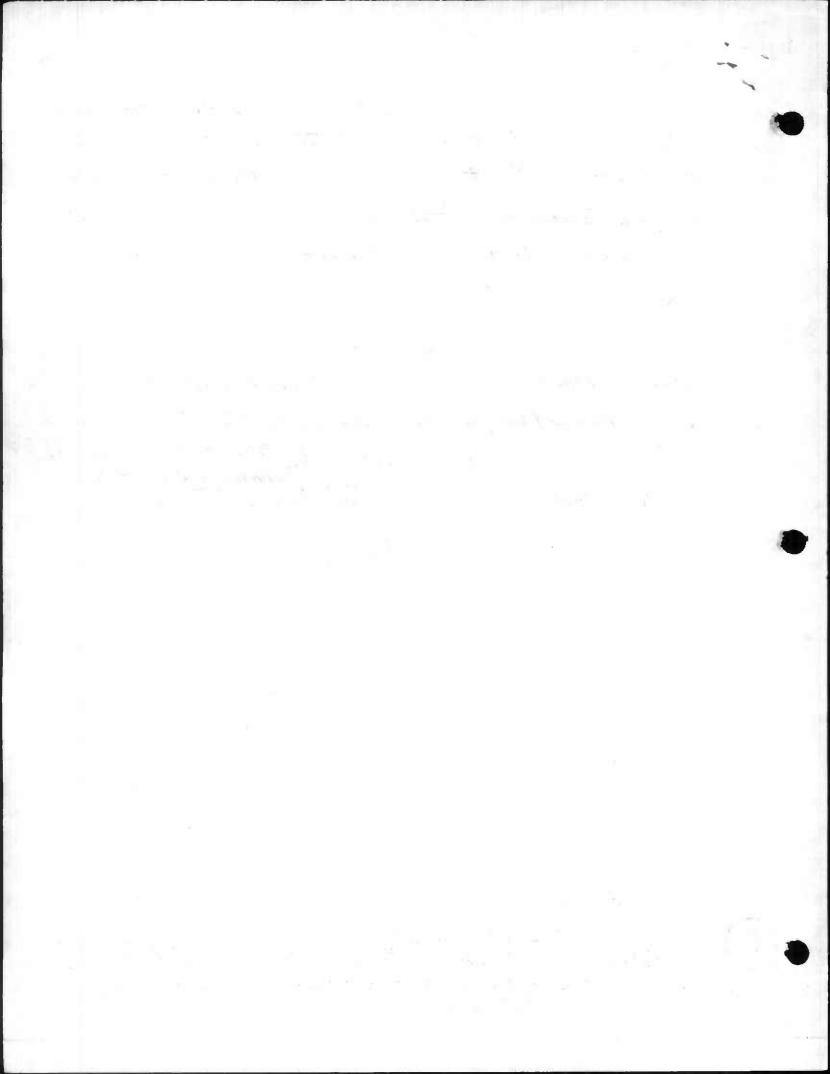
ITEM: 8 per FH G-751 9-11-97 eoh

Certificate of Death Item7 9-15-97 FilmG751 W.H.per F/H 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Day **Physician** Month BEULAH BESS September 6, 1997 8:05 a.m. /Medical 4a. Facility Nema (If not institution, give straat and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Maris BAITHOLE HOSPICE StE/la 10 W500 1916 9. Birthpiece (State or Foreign Country) If Undar 1 Yaar If Undar 24 Hrs. 8. 5. Social Sacurity Number 6 Say 7. Age (In yrs. lest birthday) Date of Birth (Month, Dey, Year) **Funeral** 1 M 200 F Deys Hours 215-22-8723 to Maryloso Yrs. Director 71 81 Usuel Residence of Dacedent 10e Stete 10h County 10c. City, Town or Location na 23a or 28a-f show 10d. Inside City Limits BALTIMORE 1 2 Tes 2 No Director Towson Kary Long 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 506 Mc Monus WAY 1519 21286 Funeral filed within 72 hours after death Hems 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indien, Bieck, Whita, etc. r than "naturel", or item the Medical Examiner 1 ☐ Nevar Married 2 ☐ Married 21215-0020 1 Yes 2 No Specify: þ Specity: Black 3- Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working lith end Mental Hygiene. 27 Is marked other than "r r traumatic event, the Med OWN HOME Elamentery/Secondery (0-12) College (1-4or 5+) HOUSEWIFE 8 4 EARS

17. Fether's Neme (First, Middle, Last) Baltimore, Maryland 18. Mother's Neme (First, Middle, Maiden Sumeme) .. Pages 1 and 2 should be fill timent of Health end Mental Hy tant: If item 27 is marked oth jury or other traumatic even Be MACK EDWARD BEULAH WATKILS 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) RUSEHA BROWN T Doughter Towson, Nary (no 2/286 5/0 Mc Maries Way 20b. Pleca of Disposition (Neme of cemetery, cremetory or other p 20e. Method of Disposition Dete / 20c. Location - City or Town, Stete 9/10/9 Buriel 2 Cremetion 3 Removel from State permit. Page Department of Important: If any Injury or 22. Neme end Addrass of Fecility CHA Thon- Homis
32 40 PC15 TENTON LIM PlEasont 10wsure Nuver (mo 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Sarvice Liganuses 23a. Part Lenter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximeta Intarval Between Onset and Death **Physician** /Medicai Immediate Cause (Final disaesa or condition rasulting in deeth) **Examiner** The law requires that the deeth certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Box 68760, Physician/Medical Due to (or es a consequence of): use as the P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 6 1 Yee 2 No 3 Probably 4 Unknown signed t Records, ģ 24b. Were eutopsy findings available prior to completion of cause of death? pege 2 should Completed 24a. Wes an autopsy performed? been hes After this certificate 1 Yes 2 No 1 Yas 2 No of Vital Be 25. Wes case referred to medical 28. Placa of Deeth (Check only one) examinar? Other: 4 Nursing Homa 5 Residence 8 X Other (Specify) HOSPICE 1 Yes 2 No 2 1 Inpatient 2 ER/Outpetient 3 DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation aturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Hospital of 24 hours a Funeral D stely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, and due to the ceuse(s) and mennar stated. edical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. Licensa number 29d. Date signed (Month, Dey, Year) 30. Neme and address of person w eath (Item 23a) (Type, Prin completed cause of DR. SHIRLEY THOMPSON-RICHARDS 2300 DULANEY VALLEY RD. TIMONIUM, MD 31. Dete filed (Month, Dey, Year) SEP 1 1 1997 32. Registrar's Signature State

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

27467

| | | | | State of Marylai | | ite of Death | and the same of | leg. No. | | . 1401 |
|------------|---|-------------------|--|--|--------------------------------|--|--|-----------------------------|---------------------------------|--|
| | Physic /Medi | | Decadant's Nama (First, Middle, Last E O | C. BI | Rown | | 2. Dete of Dee Month Sept. | Dey 10 | Year 97 | 3. Time of Death |
| | Exami Funeral Director | ner | 311-01-010 | UR HOSF | | BAL ar 1 Yaar if Under 24 Hrs | | 4c. County | 9. Birthplec | 9 e (Steta or Foreign 2 y L AND |
| | Maryland I show | tor | Usuel Rasidence of Decedent 10a. State 10b. County MAR //LAND | 10c. Ci | ty, Town or Location | BALTIHOR | ~ | 71/ | 10d. | Inaide City Limita 1X Yes 2 No |
| | with the | I Director | 10e. Street end Number | LTIMORE S | 10f. 2 | ip Code | | Og. Citizen of V | Whet Country | ? |
| 020 | d within 72 hours after death with the Maryland jiene. r than "natural", or itema 23a or 28a-f show than Maskel Examinat must be retilied at | by Funeral | 11. Marital Status 12 Never Married 2 Merried 3 Widowed 4 Divorced | 12. Was Decedent Evar in L Armed Forcas? 1 ☐ Yes 2% No If Yes, Give Yeer or Detes: | J,S. 13. Was Dec If Yas, sp | edent of Hispenic Origin? (Secify Cuben, Mexican, Puer | Specify Yas or No- rto Rican, etc.) | | a - Amarican ck, White, etc. | |
| 21215-0020 | within 72 ane. than "nat | Completed | 15. Decedent's Ed (Specify only highest grad Elementery/Secondary (0-12) 12THGRADE | ucation de completed) College (1-4or 5+) | 0 | ual Occupation vork done during most of wo use retired) RACTO R | | 16b. Kind of Bu | | - |
| Maryland 2 | be filed tal Hyg od othe event, | To Be Co | 17. Fether's Neme (First, Middle, Lest) | 45HINGTON | | 18. Molher's Na | me (First, Middle, | | na) | -1165 |
| | 1 and 2 : Health ar em 27 Is | | 19a. Informent's Neme/Relationship (7) KEVIN BROWN 20e. Method of Disposition | Type, Print) (BROTHER) 20b. | | SS (Street end Number or REEN) MOUN | TAVE. | r, City or Town, | Steta, Zip Co | D. 21218 |
| Baltimore | permit. Pages Department of I important: If its any Injury or o | | 1 | Hemovel from State | 7. ZION (| CEMETERY and Address of Facility B | eown: | JR. FUL | ERAL | HARYLAND HOMEP.A. |
| | Physician | | 23 Pert1. Enter the disease, or comp shock or heert feilure. List only of | olicetions that caused the deep one ceuse on each line. | th. Do not enter the mo | O N. FULTO ode of dying, such es cardia | C or respiretory err | ue, BA | Ap | D. 2/2/7 oproximeta tervel Between nset end Death |
| | /Medicai Examiner | Jer | Immediate Cause (Finel disaasa or condition resulting in death) | e. HEM | or as a consequence of | 25 | 3 | 0 | - 1 | day |
| x 68760, | auth certificate be executed attending physician and I lor use as the burial-transit | /Medical Examiner | Sequentielly list conditions, if any, leeding to immediate ceuse. Enlar Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest | b. Due to (c | or as e consequence of | | | Cer | | yesi |
| P.O. Box | the d | Physician/N | Pert II. Other significant conditions co | ontributing to death but not res | sulting in the underlying | cause given In Pert I. | | obecco uaa coi | ntribute to the | e cause of death? |
| Records, | The law requires that ate has been signed b page 2 should be date | Completed by | | | | | 24e. Wes a parfor | in eutopsy med? | availa compl of dee | |
| Vital | | Be | 25. Wes case referred to medical exeminer? | | | | eth (Check only or | ne) | 1 4 | es 2 No |
| of | hys hys | ation: To | 1 Yes 2 No 27. Manner of Deeth 1 Naturel 5 Pending invasigation | 28a. Date of Injury (Month, Dey Yaer) | 28b. Time of injury | OOA Other: 4 Nursing I 28c. Injury et Work? 1 Yes 2 No | Homa 5 ☐ Reside | | | |
| Division | spital or Attending P hours after death. nears Director: After t y that in by the funera | Certification: | 3 Suicide 6 Could not be determined | 28e. Place of Injury - At h building, etc. (Special | ome, ferm, streel, fectory) | ory, office | 28f. Location (S. City or Town | treet and Numb n, Stete) | er or Rural R | oute Number, |
| | fo the Hospital or offin 24 hours after to the Funeral Direction | Medipa | one) 2 Medical Exam | rsician: To the best of my kno inar: On the basis of examine end manner stated. | ation end/or investigetld | n, in my opinion, deeth occ | urred et the time, d | ete and plece, | and due to the | e causa(a) |
| | PER | I | 29b. Signature and title of cartifier | Wes / 3 | Ding | 9c. License number 03224 | 3 | 9d. Date signed | (Month, Day | , Year) |
| | 2 | | 30. Name and eddress of person who o | 2000 | I. C. | Soltuna | NE | - | 212 | 23 |
| | Sta | | 31. Date filed (Month, Day, Year) SFD 1 1 1007 | Sula Daydon-in | indelle | • | | | | |

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vear BROCKINGTON SEPTEMBER 5, 1997 18:09 4a. Facility Nama (If not institution, give street end number, 4b. City, Town, or Location of Death 4c. County of Death ST AGNES HOSPITAL, 900 CATON AVENUE NIA BALTIMORE If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Aga (In yrs. last birthday)
Yrs. If Under 1 Year 8. Date of Birth SEPT. 15,1907 Birthplace (State or Foreign Country) 1□ M 2 KF Days CAROLINA 220-30-4663 SOUTH Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE CIT NIA 1 Yes 2 □ No MARILAND 10e. Street and Number 10d. Citizen of What Country? 2224 AVENUE 21216 USA Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) Race - Amarican Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forcas? 1 ☐ Yes 2 No If Yes, Give Yaar or Dates: 1 ☐ Navar Married 2 ☐ Married 1 ☐ Yes 20 No Specify: 3 A Widowed 4 □ Divorcad BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) 7+H GRADE OWN DOMESTIC HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) UNKNOWN KAYMOND BENJAMIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) GRAND GATHERS DAYOHER 2575 EDMONDSON ALFREDA BALTIHORE, HD. 21223 20c. Location - City of Town, State AVE. 20a. Method of Disposition

1 □ Burial 2 □ Cramation 3 □ Removal from State 20b. Placa of Disposition (Name of cemetery, crematory or other plece) Data / 9-11-97 ARBUTUS, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) CEMETERY DSEPH H. BROYUN JR. FUNERAL HOME, P.A. 21. Signature of Funeral Sarvice Licensea JOSEPH 2140 N. FULTON AVE., BALTIHORE, MD. 21217 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, leart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) UNKNOWN cardiovascular disease un known herosclerotic Due to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performad? 24b. Ware autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how Injury occurred

Brockington I Records, P.O. Box 68760, å of Vital 01116 Division

by Completed Be 20

Physician

/Medical

Examiner

Funeral

Director

28a-f show

items 23a

Pages 1 and 2 should be filed within 72 hours after inent of Heaith and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Ite

Department of Heaith ar Important: If Item 27 is any injury or other trau

Physician /Medical

Examine

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

traumatic event, the Medical Examiner must be notitied at

B

Director: 静 6 hours 1 8

> State Registrar

nun

on who completed cause of death (Item 23a) (Type, Print)

gulia Segurar Signature

30. Name and andress of per

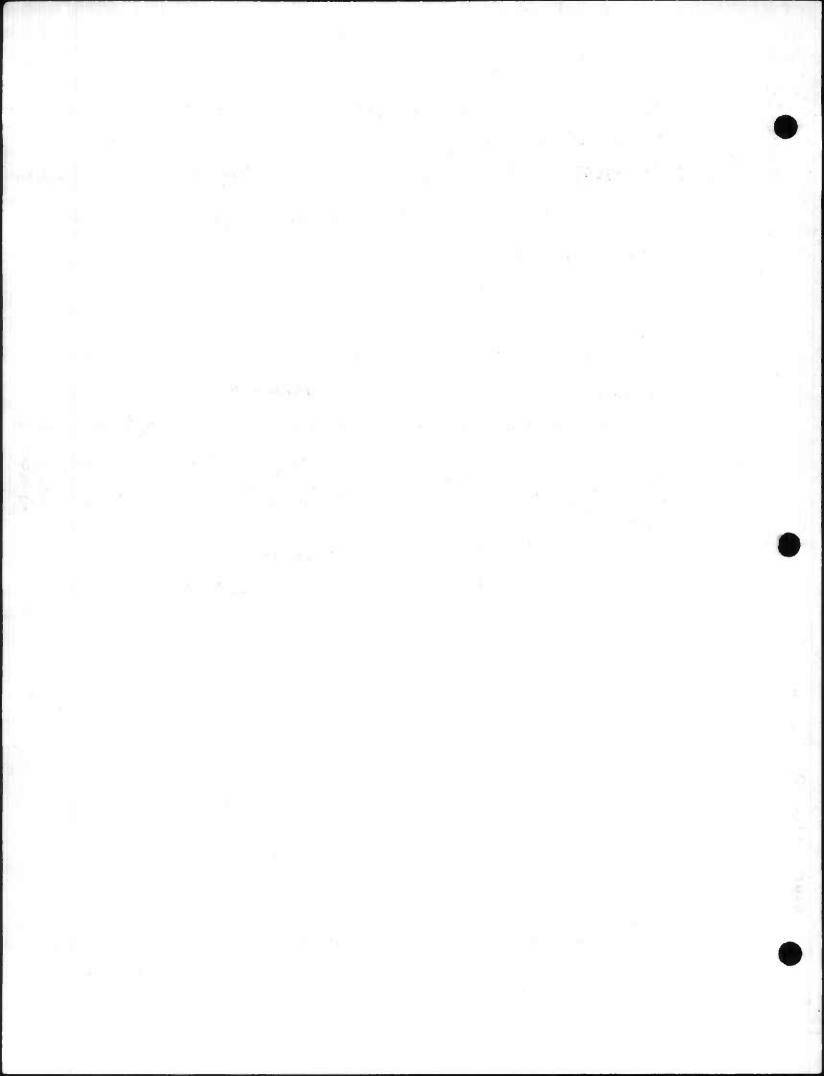
St. Agnes Huspital

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending Investigation 1 Natural 1 Yes 2 🗆 No 2 Accident 3 ☐ Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier

29c. Licansa number D 47353

29d. Data signed (Month, Day, Year) September 5, 1997

Baltimore, Maryland 21229



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

| State of Maryland / Department of Health and Mental Hygi | iene | 9 | 7 | 2 | 7 | 4 | 6 |
|--|-------|---|---|---|---|---|---|
| Certificate of Death | - 41. | | | | | | |

Reg. No. 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth 3. Time of Death SEPTEMBER ", **Physician** 1997 10:45 PM BOLLINGER SHIRLEY /Medical 4e. Fecility Neme (If not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Baltimore Saint Joseph Medical Center Towson 7. Age (In yrs. lest birthday) If Under 1 Yaar If Under 24 Hrs. 5 Social Security Number 6 Say 8. Deta of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) **Funeral** 1□M 2XF Months Deys Yrs. 64 Maryland Director 213-30-8673 April 14, 1933 Usual Residence of Decedent tha Maryland show 10e Stete 10b County 10c. City, Town or Location 10d. Inside City Limits t be notified at 1 Yes 2 No Baltimore Director Baltimore City Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with United States 21214 Examiner man 2713 Louise Ave. daath Funeral 14. Rece - Amarican Indian, Bleck, White, atc. 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) filed within 72 hours aftar 1 ☐ Never Married 2 ☐ Married 21215-0020 "naturef", or 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Deles: Specify: by White 3 X Widowed 4 □ Divorced Completed The Medical 16e. Decedent's Usuel Occupetion 15. Decedent's Education 16b. Kind of Business/Industry (Giva kind of work done during most of working life. DO NOT use retired) (Specify only highest grede completed) nd Mental Hygiena. marked other than Elementery/Secondery (0-12) College (1-4or 5+) Potato Chip Company Payroll Clerk 12 years traumatic event, Baltimore, Maryland 17. Fether's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be nant of Haalth end Mental Mildred Perkens Wagner Leonard 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) -00 Haalth e Baltimore, MD 21234 Mr. Karl M. Bollinger / Son 8100 Oakleigh Road or other 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Department of Important: If any Injury or once. Parkville 4 ☐ Donetion 5 ☐ Other (Specify) 9/13/97 Parkwood Cemetery 21. Signeture of Funeral Service Licensee Michael E. Canapp 22. Name end Address of Fecility Leonard J. Ruck, Inc. Michael 5305 Harford Rd. Baltimore, MD 23a. Pert1. Enter the disease, or complications that coused the deeth. Do not anter the mode of dylng, such as cerdiec or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximata Interval Between Onsat and Death **Physician** MINUTES VENTRICULAR ARRYTHMIA /Medical tmmediete Ceuse (Final disease or condition resulting in deeth) **Examiner** Due to (or as e consequence of): Examiner MONTHS CONGESTIVE ISCHEMIC CARDIOMYOPATHY sleian and burial-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in daeth) Last Dua to (or es e consequence of): Box 68760. DAYS physician MYOCARDIAL INFARCTION Physician/Medical the Dua to (or es e consequance of) 98 YEARS CORONARY ARTERY DISEASE usa for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death?

The law requires that the death certificate be executed P.O. signed by Records. page 2 should Division of Vital tal or Attending Physician: The safer death.

It blictor: After this certificate of in by the funaral director, pr

þ

Completed

Be

2

Certification:

edical

Yee 2□ No 3□ Probably 4□ Unknown

DIABETES

24b. Were eutopsy findings available prior to completion of ceuse of death? 24e. Was en eutopsy performed? 1 Yes 2 No 1 ☐ Yas 2 ☐ No

25. Wes case referred to medical exeminar? 1 ☐ Yes 2 ☐ No 27. Manner of Deeth 5 Pending Investigation

Hospitel: 1 □ Inpatient 2 □ ER/Outpetient 3 □ DOA 28b. Time of

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

26. Plece of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

29a. Certifier (Check only one)

2 Accident

3 Suicide

4 Homicide

1 Certifying Phyeiclan: To the best of my knowledge, deeth occurred et the time, daie and place, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated.

29b. Signature end title of certifier

31. Dete filed (Month, Day, Year)

29c. License number D31826

29d. Date signed (Month, Dey, Year)

9-10-97

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

RICHARD LINTHICUM M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204

State Registrar

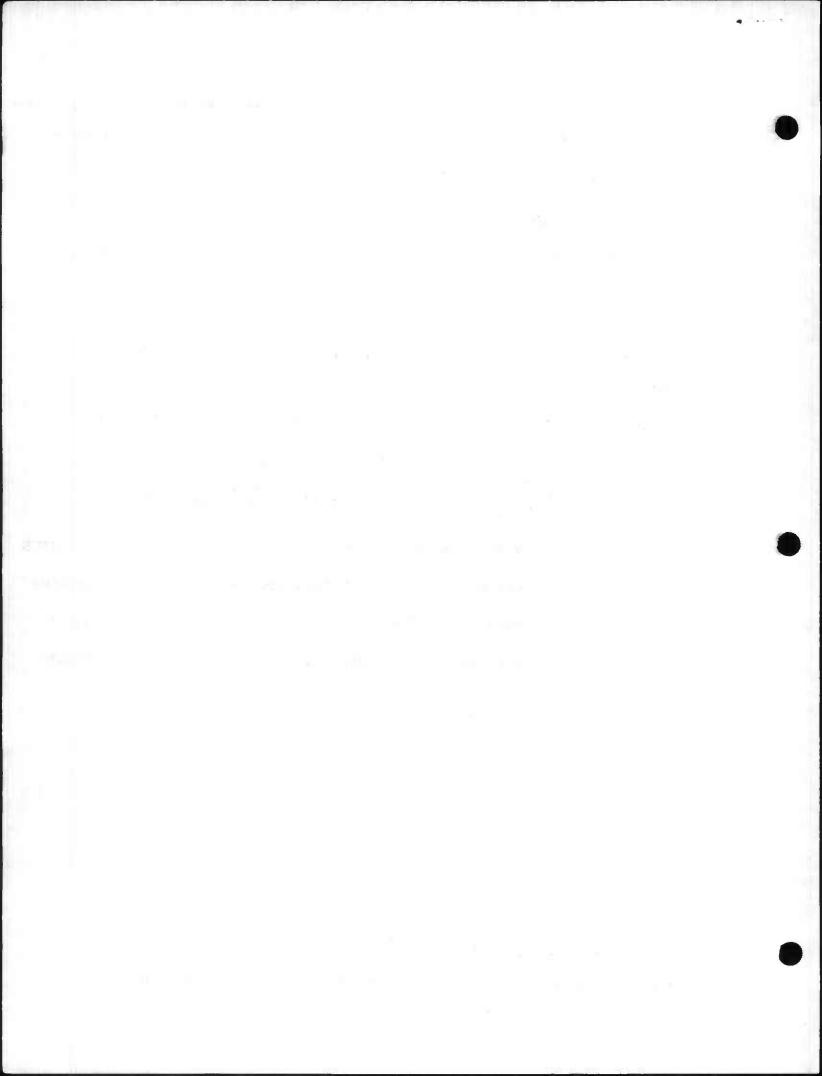
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tely !

SEP 1 1 1997

6 Could not be determined





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiona 0.7

| | | | ITEM: 26 per DR. G-751 9 | 9-11-97 eoh | Certificate of | | | Reg. No. | 1 6 | 1410 |
|----------------------------|--|-------------------|---|--|---|----------------------------|------------------------------------|--|--------------------------------------|---|
| | Physic /Medi | | 1. Decedent's Name (First, Middle, Last) THELMA | BALTIN | | | 2. Date of De Month | nber 3 | 1997 | 3. Time of Death 1:40 pm |
| | Examii Funerai Director | ner | 037-44-1045 | Seneral | Hospital | | 8. Date of Bir | th iy, Yegr) | 9. Birthple | ace (Stata or Foreign y) Syl Va AIQ |
| | the Maryland 28a-f show | tor | Usual Residence of Decadent 10a. State 10b. County NG | 10c. City, T | Town or Location | | | | | d. Insida City Limits 1 ☐ Yes 2 ☐ No |
| | 123e or 28e | i Director | 10e. Street and Number | 4 | 10f. Zip Code | 1217 | | 10g. Citizen of V | Vhat Countr | y? |
| 020 | items items | by Funerai | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorcad | 12. Was Decedent Evar In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: | 13. Was Dacedent of I If Yes, specify Cub | | pecify Yes or No o Rican, atc.) | af | a - Amarica ck, White, et amer | tc. |
| 21215-0020 | within ane. than | Completed | 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) | cation completed) College (1-4or 5+) | 6a. Decadent's Usuel Occup (Giva kind of work done life. DO NOT use retire | during most of wor | king | Social | | erity adm. |
| Maryland | d 2 should be filed th and Mental Hygi 7 is marked other treumetic event, I | To Be | 17. Father's Name (First, Middle, Last) Joseph Mark | | | 18. Mother's Nan | Walk | er | | |
| | 1 and 2: Health ar em 27 is other trau | | 19a. Informant's Name/Relationship (Typ. Roland Baltynor) 20a. Method of Disposition | e 20b. Plac | 19b. Mailing Address (Street 216 N. Fulask e of Disposition (Name of prery, crematory or other pla | rist, B | alto M | d. 212 20c. Location | 17 | |
| Baltimore, | permit. Peges Depertment of I Important: If ite any injury or o | | 1 Surial 2 Cramation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensii | 14)- | ZION 23. Nama and Addre | ess of Facility L. RUSS | 2225 | - | mor | |
| | Physician | | 23a. Fart1. Enter the disease, or compile shock, or heart failure. List only on | cations that caused the death. If e ceuse on each line. | | | | rrest, | 1 | 2/2/6 Approximata Interval Between Onset end Death |
| | /Medical Examiner | 16 | Immediate Ceuse (Final disease or condition resulting to death) a. | Pulmonar Due to (or es | y Throi | m boe i | n 60/1 | EXAMINER | | |
| 0, | ificata be axecuted g physician and as the burial-transit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter UndarlyIng | Due to (or as | s a consequence of): | CERTIFICATION APPR | MED BA MED. | | | |
| ox 68760, | E 0 4 | /Medical | Cause (Disease or Injury that Initiated events resulting in death) Last | 357 | a consequence of): | CERTIL | | | | |
| P.O. Box | the death cert by the attendin | Physician/M | Part II. Other significant conditions cont | | | ven in Part I. | | | | the cause of death? |
| | as that igned b | by | fracture of | Right F.L | rula. | | | Yes 2□ No | 3 Probe | e autopsy findings |
| Recor | Ne Se Se Se Se Se Se Se Se Se Se Se Se Se | Completed | | | | | perio | en eutopsy rmed? | evall | leble prior to pletion of cause path? |
| Vital | ysician: The last certificate hadirector, page | Be | 25. Wes case referred to medical examiner? | | 1 | 26. Plece of Dea | | Yes 2 No | 1,20 | Yes 2□ No |
| Division of Vital Records, | this al di | ation: To | 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation | 28a. Date of Injury (Month, Day Year) | b. Time of lnjury 28c. tnjur | | 28d. Describe | dance 8 Other how injury occurr & Full | red | ome |
| Divi | i di alto | al Certification: | 3 Suicida 6 Could not be determined 29a. Certifler 1 Certifula Physics | 28e. Placa of Injury - At home building, etc. (Specify) | Home | me date and place | 13011 | mone /1 | nd. 2 | |
| | To the Hospital within 24 hours a To the Funeral completaly filled | Medical | | er: On the basis of examination end manner stated. | end/or Investigation, in my o | opinion, death occur | red at the time, | date end placa, a | and due to t | he ceuse(s) |
| 1 | \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | | Mys swe | Chang | 89 | 268 | | 9/6 | 197 | |
| 1 | JA " | | 30. Nama end address of person who con | npleted cause of death (Item 23 | e) (Type, Print) Ma | ryland | Gene | eral 1 | 4051 | oital |

State Registrar 31. Dete filed (Month, Day, Year) SEP 1 0 1997

whia Davidson-Randall

| Physician /Medical | | 1. Decedent's Name Frances | (First, Middle) Milc | 1 | BRIL | .L | | | | | | 2. Data of Do Month Septem | Day | Year 1997 | 3. Time of Death 3:00 A.M | | | | |
|---|--------------|---|--------------------------------|-------------------------------------|-----------------------|---|---|--------------------------|----------------|--------------|---------------------------------|-----------------------------------|--------------------------------|--------------------------------|--|--|----------------------------|-------|--|
| Examiner | ľ | la. Facility Name (II Franklin | | | | enter | | | | 4b. City, To | | ocation of Dea | | unty of Daat timore | | | | | |
| Funeral Director | | Franklin Squa 5. Social Sacurity Number 212-16-9165 Usual Residence of Decedent 10a Stele 10b Count | | | | (In yrs. lest birthdey) | | If Under Months | 1 Year Days | | Under 24 Hrs. 8. Date (Mon July | | rth ey, Year) 7, 1912 | 9. Birthplaca (Steta or Foraig | | | | | |
| a-f show | 1 | Maryland | 10b. County | more Cou | nty | 10c. City, T | fown or Lo | | | | | | | | 10d. Inside City Limits 1 ☐ Yes 2 ☐ No | | | | |
| 23a or 28a-f s | | 10e. Street and Nun | nber | | | | | 10f. Zip | Code 206 | | | | 10g. Citizen | | puntry? | | | | |
| natural, or terms 23a or 28a-f show sizel Exact for Institut or notified at etc. Institut or notified at etc. Institut or notified at etc. Institut or notified at etc. Institut or notified at etc. Institut or notified at etc. | 1 | 11. Marital Status 1 ☐ Never Marri 3 🏿 Widowed | | If Yes G | orces? 2 XN ive | | | Vas Deced Yes, spec | | | | pecify Yes or N o Rican, etc.) | | Black, Whit | ricen Indian, e, etc. | | | | |
| "naturi edical | De Completed | (Spec | 15. Deceden ify only highas | t's Education of grede completed |) | 1 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | | | | | king | 16b. Kind of Business/Industry | | | | | | |
| or than | | 7 th Grad | | College | (1-4or 5- | | Homen | | se reine | <i>,</i> u) | | | Own I | Home | | | | | |
| ed out | | | ם מ | | 1 | 17 | 17. Father's Name (Frank | First, Middle, Joseph | | k | <u> </u> | | | | 18. Moth | | ne (First, Middle Belle | Oakle | |
| 27 is mu | | 19a. Informent's Na Audrey B. | | | | | | | | | | rel Route Numb , Balti | | | Zip Code) and 21206 | | | | |
| artment of Heal ortant: If Item 2 Injury or other | \vdash | 20e. Method of Disp 1 X Buriel 2 ☐ 4 ☐ Donation | Cremation | 3 Ramoval from | State | 20b. Place of Disposition (Name of cemetery, cremetory or other place Baltimore Cemeters | | | ther ple | , | | Date 9/12/97 | | | Town, State Maryland | | | | |

21. Signat of Funeral Service Licenses ter the disease, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or respiratory arrast, Approximate theart failure. List only one cause on each line.

John C. Miller, Inc.

Approximata Interval Between Onset and Deeth

Immediete Cause (Final disaase or condition resulting in death)

a Urosepsis Due to (or es a consequence of):

7 days

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest

Due to (or as a consequence of):

Due to (or es e consequence of):

| art II. Other significant conditions | contributing to death but not resulting in the underlying cause given in Pert |
|--------------------------------------|---|
| Cerebrovascular | Accident |

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

Dementia, Hypertension

Non-Insulin Dependent Diabetes Mellitus

24b. Wara autopsy findings available prior to 24a. Was an autopsy complation of ceusa of death? 1 Yas 2 XNo

26. Place of Deeth (Check only one)

1 Yas 2 No

25. Was cese referred to medical examiner?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

27. Manner of Death 1 Naturel 2 Accident 3 Suicida

4 Homicide

1 Yes 2 No

5 Pending Investigation 6 Could not be determined

28b. Time of 28c. Injury et Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

(Check only one)

The Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner ss stated.

2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signatura and title of certifian

29c. Licanse number

29d. Date signed (Month, Dey, Year)

Location (Street end Number or Rurel Route Number, City or Town, Stete)

RD 1914

September 10 1997

30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print)

9000 Franklin Square Drive Baltimore, Md. 21237 Dr. Katherine Hatmaker

State Registrar 31. Date filed (Month, Dey, Yaer) SEP 1 1 1997



Impatient 2 ER/Outpatient 3 DOA

Physician /Medical

Examiner

pue

physicler

use es the

sate hes been signated by page 2 should by

To the Hospital or Attending Physician: within 24 hours after death.

O the Funeral Director: After this certifical completely filled in by the funeral director, I

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Examiner

Physician/Medical

by

Completed

Be

10

Certification:

Medicai



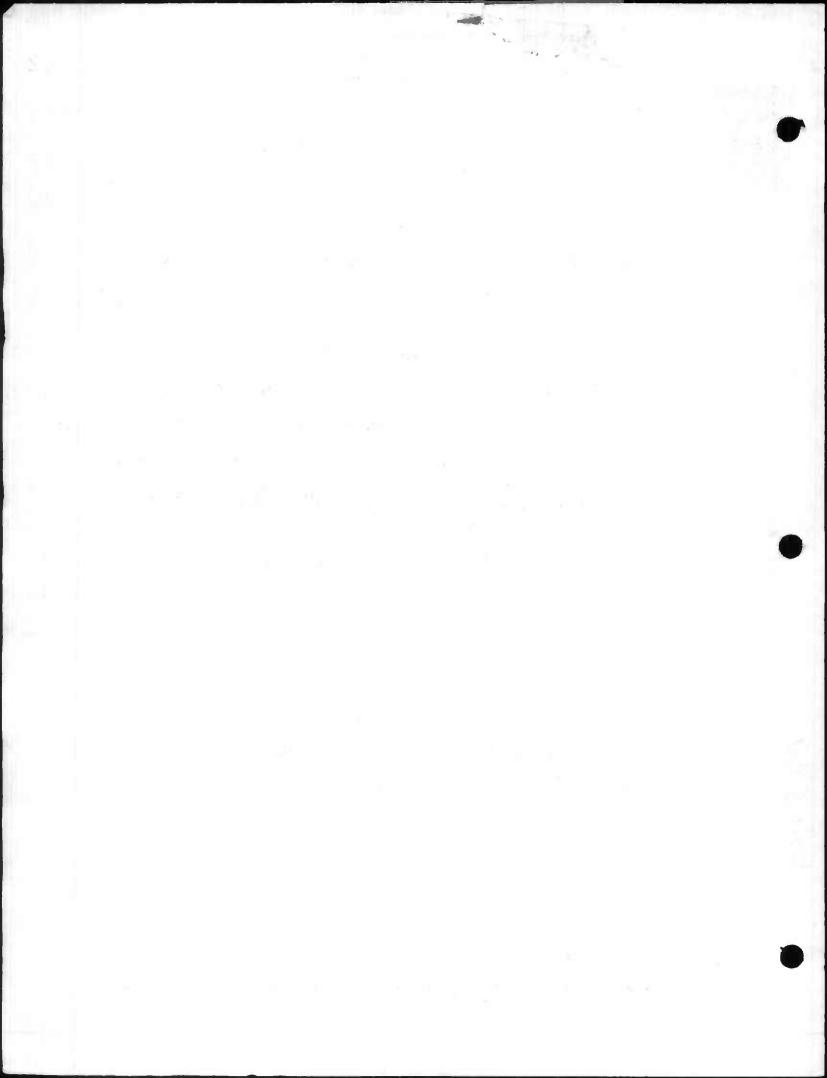
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

state of Maryland / Department of Health and Mental Hygiene 27472 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Deeth **Physician** KEVIN S. 09-05-97 8:15 PM /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 413 ROBERT STREET (HOME) BALTIMORE N/A If Undar 24 Hrs. Hours Min. 5. Sociel Security Number If Undar 1 Yaar 7. Aga (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) 04-17-62 Birthplece (Stafa or Foraign Country)
 MD . **Funeral** Months Deys 35 218-80-4740 Director Usual Rasidance of Dacedent with the Maryland 10a Stata 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or itama 23a or 28a-f show other traumatic avant, the Medical Examiner must be not it ad at 10d. Insida City Limits Director Mas 2 No MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 413 ROBERT STREET 21217 death v USA Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2#☐ No If Yas, Giva Yaar or Datas: 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amaricen Indian, 11. Marital Status Black, White, at AFRO filed within 72 hours effer Hygiene. Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: AMERICAN þ 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry permit. Pages 1 end 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than any Injury or other traumatic avant, the Maganta. Elemantary/Secondary (0-12) Collega (1-4or 5+) SOCIAL WORKER D.S.S. 12 17. Fethar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Malden Sumema) Be MARSHALL S. COOK HAZEL R. CROSBY 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) RANDALLSTOWN, MD. ROBERTA PEACE 8824 STONEHEAVEN RD. SISTER 21133 20e. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, State Dete 1 Burlal 2 Cremation 3 Ramoval from State 4 Donation 5 Othar (Specify) ARBUTUS MEM. PARK 9/9/97 ARBUTUS, MD. 21. Signetura of Funeral-Sarvice Licensaa 22. Nama and Address of Fecility ESTEP BROTHERS 1300 EUTAW PL. FUNERAL HOME P.A. BALTIMORE, MD. 21217 23a. Part1. Enter the disease, or complications that cause of least. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each light. Approximata Interval Between Onset and Death 200000 **Physician** Immediate Ceuse (Final diseese or condition rasulting In daath) HOLLOW OLDO /Medical Examiner Due to (or as a consequence of): Examiner ettending physician and for use es the buriel-transit Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury Dua to (o) as a consequence of): P.O. Box 68760. Physician/Medicai that initiated avants rasulting in death) Last Dua to (or as a consequence of): 98 950 Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the 28 NO 3 Probably 4 Unknown 1 Yee þ 24b. Were autopsy findings evellable prior to complation of ceuse of daath? 24a. Wes en autopsy performed? Completed hes certificate 1 ☐ Yas 1 TYas 2 TNo Division of Vital or Attending Physician: funeral director, 25. Was cesa rafarracto medicel axaminar?
1 ☐ Yas 2 ☐ No Be 26. Place of Deeth (Check only one) Hospital: Othar: 4 ☐ Nursing Homa Sidance 6 ☐ Othar (Specify) 10 1 Inpatiant 2 ER/Outpetient 3 DOA efter death. Director: After this 28a Deta of Injury (Month, Day Year) 27. Manner of Death Certification: 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 5 Panding invastigation 1 Natural 8 No 1 Yas 2 Accidant 6 Could not be datarmined 3 Suicide 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital owithin 24 hours of To the Funeral D Medical Examinar: On the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

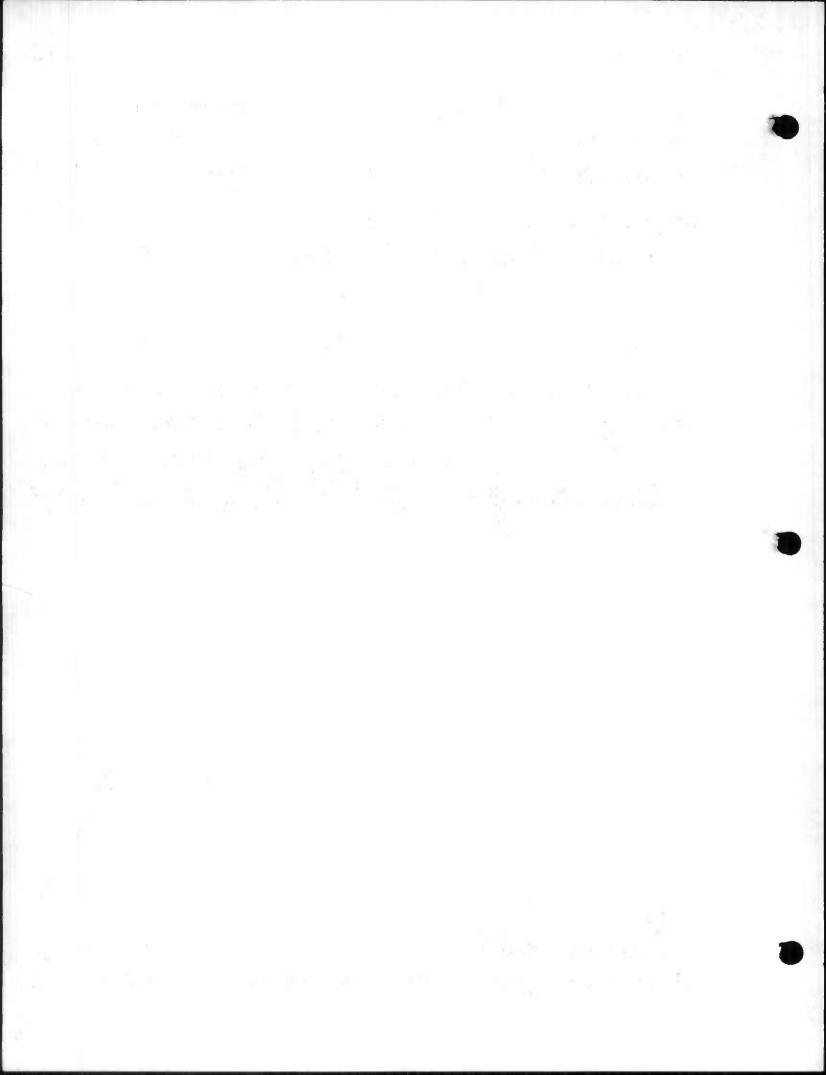
Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Cartifier Medical pletely (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifiar 29c. License numbar 30. Neme end addrass of person who completed cause of deeth (Item 23e) (Type, Print) 4000 Old Covet RJ Vikesville Mo Michael Suite 200 21208 Levin

DHMH 16 Rev 6/95

State Registrar 31. Data filed (Month, Day, Year) SEP 1 1 1997



| JEROME B | • | CHASE 2nd | State of Maryland | / Department of | Health and M | ental Hyg | iene 9 | 7 27473 |
|--|----------------|---|--|--|--|-----------------------------------|-------------------|---|
| asp Items | 23 | a part I,27 per MEO G-7 | 51 9/20/97 dh | Certificate of | f Death | R | eg. No. | |
| Physici | an | 1. Decedent's Name (First, Middle, Las | 0 11 7 | _ | | 2. Date of Deat Month | h Day | 3. Time of Death |
| /Media | | JEROME K | D. Chase, J | R. | | | BER 02 | |
| Examin | er | 4a. Facility Name (If not institution, give | street end number) | | 4b. City, Town, or Lo | cation of Death | 4c. County | |
| | | DOCTORS HOSPITAL 5. Social Security Number 6. Sc | ex 7. Age (In yrs. les | at hirthdey) If Under 1 Yaa | LANHAM If Undar 24 Hrs. | 9 Date of Birth | | E GEORGES |
| Funeral Director | | | 2 Age (in yrs. les | Yrs. Months Day | | 8. Date of Birth | 997 | 9. Birthplace (State or Foreign MARY) And |
| deeth with the Manyland ms 23a or 28a-f show rmuit be not trad at | | 10s. State 10b. Sounty | 10c. City, | Town or Location | | | | 10d. Insida City Limits |
| the Maryland r 28a-f show | ctor | MARYland PRINCE | George Rel- | tsville | | | | 1 Yas 2 No |
| ih th | Directo | 10e. Speet and Number | Tolon | 10f. Zip Code | 0 | 1 | Og. Citizen of V | Vhat Country? |
| eeth w | ra | 11340 BVANS | IRAIL THAT | 204 20 | 107 | | U. X | M, |
| items items | Funeral | 11. Marital Status | 12. Was Decedant Every U.S. Armed Forces? | Was Dacedent of If Yes, specify Cu | Hispanic Origin? (Spe ban, Maxican, Puerto | city Yes or No- Rican, etc.) | | e - Amarican Indian, k, White, etc. |
| | by F | 1 Never Married 2 Married 3 Widowed 4 Divorcad | 1 ☐ Yes 2 ☑ No If Yas, Give Year or Dates: | 1 □ Yes 210 No | o Specify: | | Specity | Black |
| 21215-0020 d within 72 hours efter jiene. r than "neturel", or fte | | 15. Decedent's Ed | ucation | 16a. Decedent's Usual Occ | upation | | 16b. Kind of Bu | usiness/industry |
| within 7 within 7 sene. | Completed | (Specify only highest green Elamantary/Secondary (0-12) | de com <i>platad)</i> Collaga (1~4or 5+) | (Give kind of work don life. DO NOT usa ratii | e during most of working) | ng | . / | 10 |
| | Con | 0 | | 147 | 4 | | NI | 777 |
| C 0 5 0 > | Be | 17. Father's Name (First, Middle, Last) | | - 60 | 18. Mother's Nama | (First, Middla, I | Aaidan Sumam | 1// |
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| Mar ind 2 sh alth and 27 Is m | | 19a Informant's Name/Ralationable (7 | (hasoso | 19b. Malling Address (Street | et end Number of Hure | Routa Number | Rolle 1 | Stete, Zip Code) |
| | Í | 20a. Method of Disposition | 20b. Plac | ce of Disposition (Name of | ms Nati | Date | 20c. Location - | City or Town, State |
| no page anto y or | | 1 Burial 2 Cremation 3 4 Domation 5 Other (Specify | Removal from State | netery, cremetory or other pi | (ece) | 10197 | Cost | . 16 ml |
| Balting permit. Pe Department Important: any Injury | | 21. Signature of Funaral Servica Licent | | CU CREMATO | res of Facility | 10/14 | CHION | SA AK TINE |
| Ball permi Depa Impo any Ir | | Den Co | (Jones | MARSHA | MO JON | حربارد. | DATE | MJ 21229 |
| | _ | 23a. Part1. Entar the disease, or comp | lications the death. | Do not writer the mode of de | moncs or | r respiratory arm | SH TO | Approximate |
| Physician | | shock, or heart failure. List only o | ne cause of much line. | | | | | Interval Batween Onset and Death |
| /Medical | | Immediate Cause (Final diseasa or condition | SUDDEN INFANT | DEATH SYNDROME | | | | |
| Examiner | | rasulting in daath) | a. | is a consequance of): | | | | |
| led Insit | Examiner | | b | | | | | |
| 60, be executed icien and burial-transit | xar | Sequentially list conditions, if any, leading to immediate | Dua to (or a | s a consequence ot): | | | | |
| 58760, icete be e physicien s the burie | dicail | if any, leading to immediate cause. Enter Underlying Causa (Diseasa or injury that initiated events | C | s a consequence of): | | | | |
| 687 tificete ig phys | (a) | resulting in death) Last | Due to tot a | s a consequence or). | | | | |
| Box 6 death certific | Physician/M | | d | | | | | |
| O. B. | sici | Part ii. Other significant conditions co | ntributing to death but not resulti | ng in the underlying cause of | given in Part I. | 23b. Did to | bacco use cor | ntribute to the cause of death? |
| - + You | Phy | | | | | 1 🗆 Y | es 2 No | 3 Probably 4 Unknown |
| ds, Fires that signed d be det | by | | | | | | | T., |
| cords v requires been sign should be | etec | | | | | 24a. Was a perform | n autopsy ned? | 24b. Were autopsy tindings available prior to completion of causa |
| Hes hes | Cômpieted | | | | | 1.4 | | of death? |
| | | or we | | | | | s 2 No | 10 Yes 2□ No |
| Vital | To Be | 25. Was case refarred to medical examiner? 1X Yas 2 □ No | Hospital: 1 ☐ Inpatiant 2 ☐ EF | R/Outpatient 3X DOA | 26. Place of Daath other: 4 \sum Nursing Hor | | | (0 |
| O M. Hall | | 27. Manner of Death | | 8b. Time of 28c. Inj | | 28d. Describe h | | |
| IOT Partie | atio | 1 XXNatural 5 ☐ Pending 2 ☐ Accident Invastigation | | | ork? ☐ Yes 2 ☐ No | | | |
| Division Tor Attending of the doubt Director: After doubt at the doubt at the figure doubt. | Certification: | 3 ☐ Suicide 6 ☐ Could not be datermined | 28e. Place of Injury - At home building, atc. (Specify) | e, farm, street, factory, office | 8 2 | 28f. Location (Si City or Town | reat end Numb | er or Rurel Route Number, |
| Lis efter | | | gi war (opoury) | | | | | |
| Division of Allen or Allen or Allen or Allen or Allen or Allen or Orbital or Allen or Orbital or Allen | edicai | | sician: To the best of my knowle Iner: On the besis of examination | | | | | |
| the the mple | Med | 29b. Signature and title of certifier | and manner stated. | | nse number | т. | | d (Month, Dey, Year) |
| F 3 F 8 | === | N ALL | Le dul | | C.M.E | | | ER 03,1997 |
| and the second | | 20 No North | ampleted of the state of the st | | - IT.E | | | LIK UJ, 199/ |
| | | 30. Name and address of person who c | omplated some of daath (Item 2) | 3a) (Type, Print) 111 Penn Str | eet, Baltin | nore, Ma | aryland | 21201 |
| Sta | te | 31. Date filled (Month, Dey, Year) | 32. Fjøgjstrar's Signatur | · - · - · · · · · · · · · · · · · · · · | - | | | |
| Registr | | 31. Date filled (Month, Dey, Year) SEP 1 1 1997 | guia Davidso | n-Aandelle | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

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| 4 | 1 | / | -/- | u | - 1 | L |
| - | - 1 | liven. | | 4 | | -1 |

| Physician / Medical Examiner and professional professiona | 0e. Street end Number 515 Chestnut 1. Maritel Status 1 Never Merried 2 Never Merried 2 Never Merried 4 Divor | M. Aution, give st. Retire 6. Sex 10 11 Ave. Married reed adent's Education gives to grade at 12) Idonship (Type at 12) Retiremain 3 Read of (Specify) | Areet end nument (M 2 F F 2. Wes Dece Armed For 1 Tes, Giv Yes, Giv Yes, Giv Completed) College (1 | Dommuni 7. Age (In yrs. 95 10c. Cil | Jasi birthda Yrs. y, Town or TC S. 16e. Dec (Gi life House) | Location DWSON 10f. Z 10f. Z 1 Yes, sp | 2 No uel Occu ork done use retire | Hours Min. 14 Hispanic Origin? (Speen, Mexican, Puerto Specify: 15 16 17 18 18 18 18 18 18 18 18 18 18 18 18 18 | 8. Dete of Birth (Month, Dey Sept. 5. | Dey er 07, 4c. County Balt Year), 1902 Og. Citlzen of V US 14. Rac Blei Specifi 16b. Kind of B | y of Death Limore 9. Birthple Count 10 Whet Count A De - America ck, White, e y: Whit | England Inside City 1 Yes 2 Try? In Indien, etc. |
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| Important: if Item 27 is marked other than "naturel", or items 23s or 28s-1 show any injury or other treumatic event, the Medical Examiner must be notified at any injury or other treumatic event, the Medical Examiner must be notified at any injury or other treumatic event, the Medical Examiner 25s or 28s-1 show any injury or other treumatic event, the Medical Examiner 25s or 28s-1 show any injury or other treumatic event, the Medical Examiner 25s or 28s-1 show any injury or other treumatic event, the Medical Examiner 25s or 28s-1 show any injury or other treumatic event, the Medical Examiner 25s or 28s-1 show any injury or other treumatic event, the Medical Examiner 25s or 28s-1 show any injury or other treumatic event, the Medical Examiner 25s or 28s-1 show any injury or other treumatic event, the Medical Examiner 25s or 28s-1 show any injury or other treumatic event, the Medical Examiner 25s or 28s-1 show any injury or other treumatic event, the Medical Examiner 25s or 28s-1 show any injury or other treumatic event, the Medical Examiner 25s or 28s-1 show any injury or 28s-1 sho | e. Facility Neme (If not institute Pickersgill Files Social Security Number 219-42-5568 | Ave. Married reed bedent's Educe ghest grade of the control of th | Areet end nument (M 2 F F 2. Wes Dece Armed For 1 Tes, Giv Yes, Giv Yes, Giv Completed) College (1 | Dommuni 7. Age (In yrs. 95 10c. Cil | y, Town or TC | Months Location DWSON 10f. Z 10f. Z 1 yes, sp 1 yes cadent's Us ve kind of w. DO NOT | ip Code 2120 adent of lecify Cub 2 XNo uel Occupork done use retire | TOWSON If Under 24 Hrs. Hours Min. 14 Hispanic Origin? (Speen, Mexican, Puerto Specify: Ipetion aduring most of worked) | 8. Dete of Birth (Month, Dey Sept. 5., | 4c. County Balt Year) 1902 Og. Citlzen of V US 14. Rac Blei Specify 16b. Kind of B | y of Death Limore 9. Birthple Count 10 Whet Count A De - America ck, White, e y: Whit | e CO. ace (State or Fry) Engla id. Inside City 1 Yes 2 ry? In Indien, id. id. id. id. id. id. id. id |
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| lclan 2 | 21. Signature of Funeral Serv | vice Liceline | moval from a | | Thon | nae Ch | urch | Cemetery | 9/11/9 | 7 Carri | son l | ма |
| sician 2 | Dans (| | e ce | 100. | 11101 | 22. Name a | nd Addre | ess of Fecility Ru | ck Towso | n Funer | cal Ho | me. In |
| sician | C. Marco | 77 | 0 14 | 1 | | | | | 50 York | | | |
| sician | n. n. a. F | | | | | | | | | | | |
| | 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | Approximete Intervel Betwe |
| | | | | 1 . | 1 | | 1 | | | | į ' | Onset end Dea |
| di di | mmediete Ceuse (Finel liseese or condition | | me | HAST | Atic | - C | 060 | M CAN | cer | | i | 8 mo |
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| detached i | art II. Other significant cond | ditions contri | ributing to de | ath but not res | ulting In the | underlying | cause gi | iven in Pert I. | 23b. Did to | bacco uss co | entributs to | the cause of c |
| y Ph | | | | | | | | | 1 □ Y | ss 2 No | 3 Probe | ably 4 Un |
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| | | | | | | | | | 24a. Was a perform | | 24b. Wer | re eutopsy find lieble prior to |
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| 5 G CD | 5. Wes case referred to med exeminer? | | spital: | | | | 0 | tore | th (Check only on | | | |
| 불흥 | 1 Yes 2 No | | 1 11 | | ER/Outpet | | OA | 4 Nursing H | ome 5 Reside | | |) |
| funer flon: | 7. Menner of Deeth 1 Deeth 5 □ Per | ndina | 28e. Dete o (Monti | h, Dey Year) | 28b. Time Injury | | 28c. Inju Wo | iry et ork? | 28d. Describe ho | w Injury occur | rred | |
| the fr | 2 Accident Inve | estigation | No | ne | | М | 1 |]Yes 2□No | | | | |
| 至 章 | 3 Suicide 6 Cou 4 Homicide det | uld not be termined | 28e. Pleca | of Injury - At he | me, ferm, | street, fecto | ry, office | | 28f. Location (St City or Town | reet end Numb | ber or Rure! | Route Numbe |
| ed in by the Certifica | | | - Canan | ig, otor (opcon | , | | | | | ,, -1010, | | |
| 1 | an. Certifier Certif | ifying Physic | cian: To the | best of my kno | wledge, de | eth occurre | et the ti | ime, dete end pleca, | and due to the o | euse(s) and me | enner as ste | eted. |
| New Funeral | (Check only 2 Medic one) | cal Examine | er: On the ba end menn | isis of exemine ner steted. | tion end/or | investigetio | n, in my | opinion, deeth occur | red et the time, d | ate end plece, | and due to | the cause(s) |
| 1 2 3 | Signeture end title of cert | tifier | 1 | 1 | | 2 | c. Licen: | se number | 2 | 9d. Date signe | d (Month, D | ey, Year) |
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| h | D. Neme end eddress of pers | my | , | y, | _ | 2 | | | - | - Pro | | -1111 |
| 30 | D. Neme end eddress of pers | son who com | pleted caus | deeth (Iten | 23e) (Typ | e, Print) | | . CI D | 11- | 11 1 | | |
| - 6 | N. H. Kile | 4 G | -BMC | : 670 | 1 14 | -ch | AVLE. | 1 JT. B. | gito. N | 7d. 2/ | 20% | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 27475 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** Day Sept. 1997 **JAMES** LESTER CHANEY 6:55PM /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare Hamilton Baltimore N/A 6. Sex 1X M 2□ F 5. Sociel Security Number If Under 1 Year Months Days if Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) Months Yrs. 215-07-3130 88 Maryland Mar. 8, 1909 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A Baltimore Director 1⊠Yes 2□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2213 Cloville Ave. 21214 USA Funeral 12. Wes Decadent Ever in U.S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Biack, White, etc. 1 Never Married 2 Married I ☐ Yes 2 ☑ No f Yes, Give Year or Dates: 1□ Yes 2√ No þ Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) College (1-4or 5+) 12 Sheet Metal Worker Bendix 17. Fether's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be James I. Chaney Elizabeth Blanche Acton 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dorothy Soberg 2213 Cloville Ave., Baltimore, MD 20b. Piace of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1

Buriai 2 □ Cremation 3 □ Removel from State 9/9/97 Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Fusieral Service Licansee 22. Name end Address of Fecility ALTENBURG FUNERAL HOME, P.A. 6009 Harford Rd., Baltimore, MD 21214 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervat Between Onset and Death immediate Ceuse (Finat disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting In death) Last Due to (or as a consequenca of) Physician/Medical Due to (or as a consequenca of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 □ Probably 📲 Unknown þ Completed 24b. Were autopsy findings 24e. Wes en autopsy performed? completion of cause of death? 1 Yes 200 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical Be 26. Plece of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 D Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year)

State Registrar

Funeral

Director

25a-f show notified at

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items 23a

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Hygiene.

the Medical Examiner

Illed within 72 hours after

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Health and Mental marked o

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Important: I any Injury o

Physiclan /Medical

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I Director: After this d in by the funeral d

6 Hospital To the Hospital within 24 hours a To the Funeral Completely filled

director.

The law requires that the death certificate be executed

P.O. Box 68760,

Records,

Division of Vital Attending Physician:

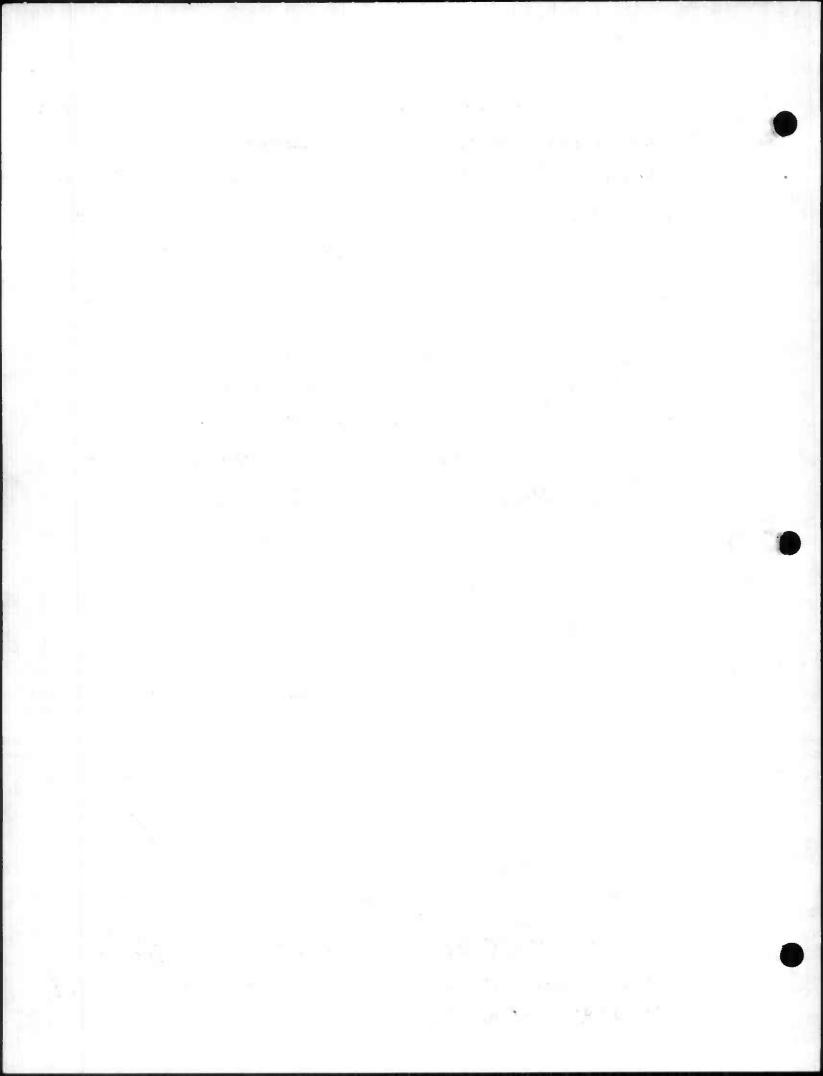
Baltimore, Maryland 21215-0020

Ziad 31. Date filed (Month, Dey, Year) SEP 1 1 1997

Northern Parkway Bolto. ms 32. Registrar's Signature what Davidson

2007 8

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)



| Plea | se Type or Pri | nt in Blac | k Indelible Ir | nk. Assure A | All Copies | Are Leg | ible. |
|--|--|--------------------------|---|--|-------------------------------------|-----------------|--|
| | | | Department o | f Health and | Mental Hyg | jiene (| 37 27476 |
| Decedent's Neme (First, Middle | (Ast) | | o or imouto | or Boatti | 2. Dete of Dea | teg. No. | 3. Time of Deeth |
| BETTY | M_ | | CHALK | | | ER 9. | 1997 11:06 AN |
| 4e. Fecility Name (If not institution. | | | CHICALITY | 4b. City, Town, or | | 4c. County | |
| Saint Josep | | Cente | r | Tow | | 4c. County | Baltimore |
| 5. Sociel Security Number 219–16–9881 | 6. Sex 7. Ag 1 □ M 2 1 F | e (In yrs. lest bi 72 | Yrs. If Under 1 Your Months De | ear If Under 24 Hrs. Hours Min. | | , Yeer) | Birthplece (State or Foreign Country) Maryland |
| Usuel Residence of Decedent | | 40 Ct T | | | | | |
| 10a. Stete 10b. County Maryland N/A | | 10c. City, Tow | Baltimore | | | | 10d. Ineide City Limits XX Yes 2 □ No |
| 10e. Street end Number 4254 Falls Road | | | 10f. Zip Coo | 2121 | | log. Citizen of | Whet Country? |
| 11. Marital Status 1 Never Married 2 Marrie 3 Never Married 4 Divorced | 12. Wes Decedent Armed Forces? ed 1 Yes 24 If Yes, Give Year or Detes: | Everin U,S. | 13. Wes Decedent If Yes, specify (| of Hispenic Origin? (S Cuben, Mexican, Puert No Specify: | pecify Yes or No- o Rican, etc.) | | ca - American Indien, ock, White, etc. fy: white |
| 15. Decedent | 's Education | 16e | . Decedent's Usuel Oc (Give kind of work do | cupetion one during most of wor | rkina | 16b. Kind of B | Business/Industry |
| Etementery/Secondary (0-12) | College (1-4or 5 | | iffe. DO NOT use re | tired) | | Retail | Sales |
| 17. Fether's Neme (First, Middle, L Charles Carl Wr: | | | | 18. Mother's Ner | ne (First, Middle, e Roser | Maiden Surner | me) |
| 19e. Informent's Name/Reletionsh Betty Wiles | olp (Type, Print) Daughter | 198 | o. Meiting Address (Sti | reetend Number or Au Court Bal | | - | |
| 20e. Method of Disposition XXBuriel 2 Cremation 4 Donetlon 5 Other (Sp | | cemete | of Disposition (Name of try, crametory or other nore Nation | piece) | | | - City or Town, State ore, Maryland |
| 21. Signature of Funerel Service L | e Carpen | tu | 22. Name end Ad Burgee-H 3631 Fal | dress of Fecility Henss Funer Is Road Ba | ral Home | , MD 21 | 211 |
| 23a. Pert1. Enter the disease, or shock, or heart feiture. List of | | | not enter the mode of | dying, such es cardiad | or respiretory en | est, | Approximete Intervai Between Onset end Deeth |
| Immediate Cause (Finel disease or condition | KESP1 | KHIUKI | / FAILURE | • | | | |
| resulting in death) | ADULT | | consequence of): | ISTRESS | SYNDROM | 1E | |
| Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying | | Due to (or es e | consequenca of): | | | | |

Physician /Medical Examiner

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certificate has t

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after death.

Director: Aft d in by the fu

hours a fumeral

director

To the Hospital or Attending Physician: The law requiras that the death certificate be axecuted

Division of Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

Funeral

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or 28a-f show

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Certification: To

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Department of Health and Mental Hygiena. Important; or Items 23a or 28s-f shot any Injury or other traumetic event, the Madical Examiner must be notified a gines. Since

with the Maryland

death

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0020

Sequentially list condition if eny, leading to immediate. Enter Underlyin Ceuse (Diseese or Injur that Initiated events resulting in deeth) Lest

Due to (or es e consequenca of):

Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I.

METASTATIC OVARIAN CANCER

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes en eutopsy performed?

24b. Were autopsy findings evelleble prior to completion of cause of deeth?

1 Yes 2 No

26. Plece of Deeth (Check only one)

1 Yes 20 No

| 25. | Wes case | referred | to | medical |
|-----|-----------|----------|----|---------|
| | exeminer? | | | |
| | 1 ☐ Yes | 250 No. | | |

27. Manner of Deeth 1 Naturet 2 Accident

3 Suicide

4 Homicide

5 Pending investigation 6 Could not be determined

28e. Dete of Injury (Month, Dey Year)

1 Inpatient 2 □ ER/Outpetient 3 □ DOA 28b. Time of

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 1 Yes 2 No

28d. Describe how Injury occurred

29e. Certifier

156 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end menner stated.

29b. Signeture end title of certifier

31. Dete filed (Month, Dey, Year) SEP 1 1 1997

29c. License number

29d. Dete signed (Month, Dey, Year)

D 30263

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

7620 YORK ROAD, TOWSON, MARYLAND 21204 FRANCIS KHOO, M. D. ,

State Registrar 32 Aggistrar's Signeture
Junia Naurdson-Randalle

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey 1997 Month CARRIE DORSETT VIRGINIA 10-30AM SEPT 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth HAZ GOND 000032003 1023 AGATE If Under 24 Hrs.
Hours Min.
April 6, 1910 North Carolina 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 6. Sex 1□M 2√3F Deys 87 242 07 7480 Yrs. Usual Residence of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Middle River 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20 Helicopter Dr. 21220 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 13. Wes Decedant of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Bleck, White, etc. 11. Meritel Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16a. Dacedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadant's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elemantary/Secondary (0-12) Dispatcher Cab Co. 17. Fether's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Eli C. Lewis Mary E. Cranford 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Route Number, City or Town, Stata, Zip Code) John B. Vinson (Grandson) 20 Helicopter Dr. Baltimore, Md. 21220 20a. Mathod of Disposition 20b. Pleca of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, Stete 1 Suriel 2 Cremetion 3 Removal from State Holly Hill Mem. Gardens 9/12/1997 Baltimore, Co. Md. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Service Licansee 22. Neme and Addrass of Fecility Bruzdzinski Funeral Home P.A. Ferf. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, thyck, or heart feiture. List only ona cause on each line. 1407 Old Eastern Avenue Essex, Md. 21221 Approximate Intervel Between Onset and Death Immediate Ceuse (Final COROJANY · A CUITE ALTENY disease or condition rasulting in daath) ASWD Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceusa (Disaese or injury that initiated events resulting In deeth) Lest Due to (or es e consequença of): Due to (or es e consequenca of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HYDERTENSION 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? complation of cause of death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Plece of Deeth (Check only one) examinar? Hospitel: 1 | Inpatiant 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residance 6 Other (Specify) 1 Yas 2 No 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Directo

Funeral

þ

Completed

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show trsumstic event, the Medical Examiner must be notiled all

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiane. Important: If Item 27 is marked other than "natural", or ther any Injury or other traumatic event, the Medical Examiner.

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Records,

Division of Vital

the Maryland

death

and physician s the burial signed t

bunial-transit Physician/Medical þ Completed Be Certification: To

Hospital or Attending Physician: Mours after death. Funeral Director: After this certifica Hospital 24 ŝ

State Registrar

PRABHU 31. Date filed (Month, Day, Year) SEP 1 1 1997

29b. Signeture end titla of cartifier

1. Neturet

2 Accidant

4 Homtelda

3 Suicide

29a. Cartifier

5 Pending

investigation

30. Name end eddrass of person who complated causa of daath (Itam 23a) (Type, Print)

6 Could not be determined



MA

NA

28e. Placa of Injury - At home, ferm, street, factory, offica building, atc. (Specify)

7

DHMH 16 Rev 6/95

Medical

29d. Date signed (Month, Day, Year)

2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred et the time, date end placa, end due to the ceuse(s) and menner steted.

1 Certifying Physician: To tha best of my knowledga, daath occurrad at tha tima, data and place, and dua to tha cause(s) and mennar as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

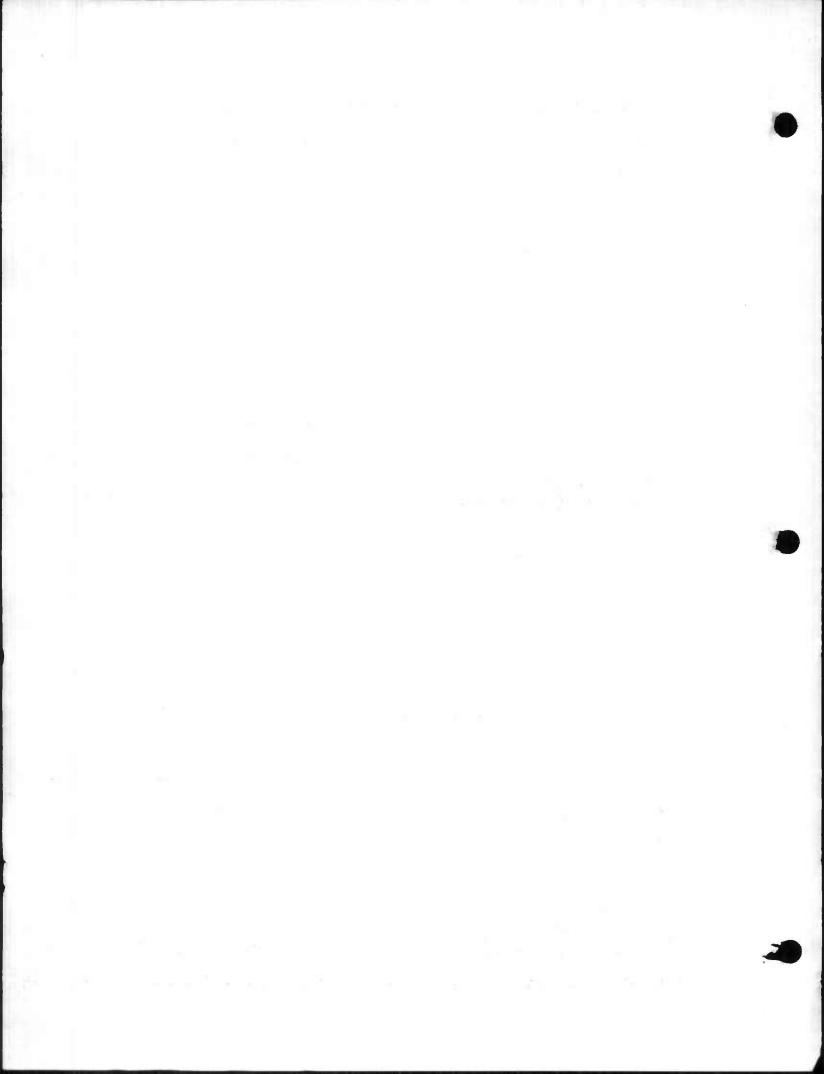
29c. License number

1 Yes 2 No

021809

SEPT 9 1997

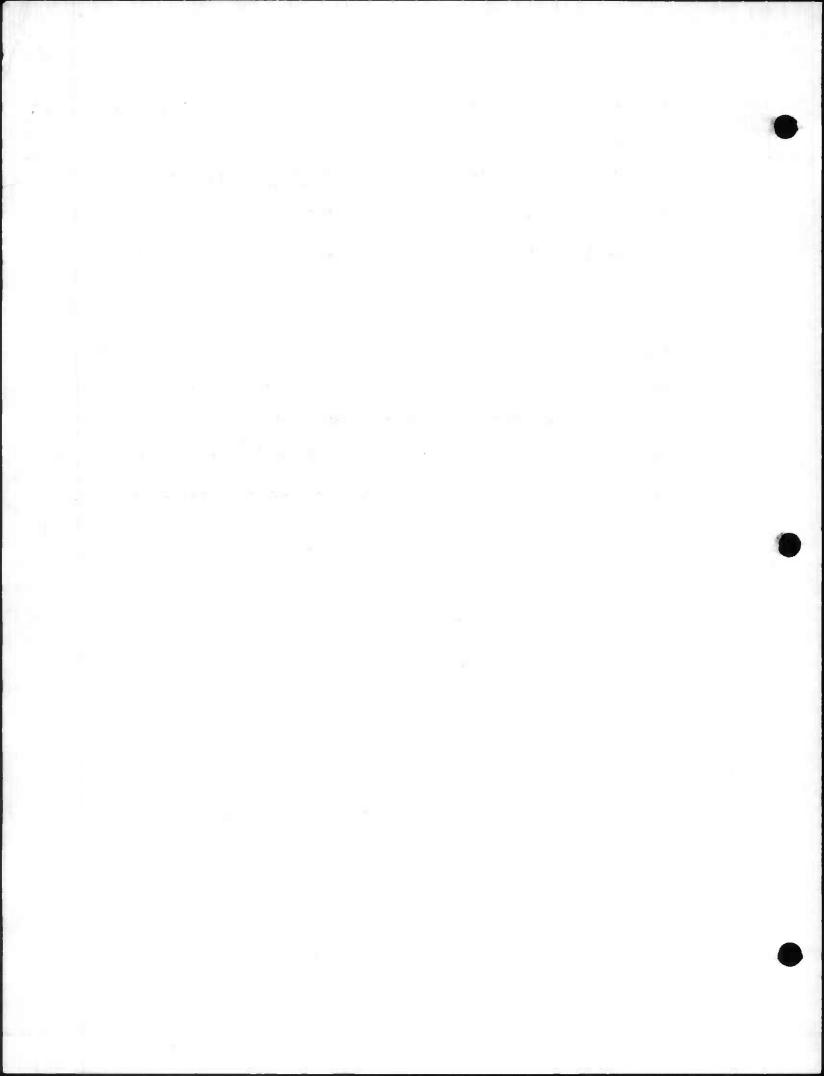
FALLSTON MOZIOHT



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State of Maryland / Department of Health and Mental Hygiene 97 271,78

| | | | | C | ertifica | ate of | Death | | Reg. No. |) I (I | 410 |
|--|------------------|---|---|--|---|-----------------------------------|---|---------------------------------------|-------------------------------|---|--|
| Phys | ician | Decedent's Neme (First, Middle, Las | t) | | | | | 2. Deta of De Month | Dev | Voor | Time of Death |
| | dical | REBECCA | DUNMORE | | | | | SEPTE | MBER | 5, 1997 | 9:05 A |
| Exar | niner | 4a. Feclity Neme (If not institution, give 3726 FLOWERTO | | | | | 4b. City, Town, or I | | | nty of Deeth | |
| Funer Direct | | 5. Social Sacurity Number 6. Sec 2 1 2 - 1 2 - 9 3 0 6 | 7. Age (In yrs. 83 | last birthd Yrs | Month | ar 1 Year s Days | | 8. Dete of Bir (Month, De APRII | rth ey, Year) 15, | 9. Birthplece Country) 1914 | (Stete or Foreign |
| Marylend -f show | tor | 10a. Stete 10b. County | 10c. Ci | ty, Town o | r Location | BAI | OT | | | | nside City Limits Yas 2□ No |
| th with the 23e or 28 | ai Director | 10e. Street and Number 3726 FLOWERTON | RD | | | ip Code 2122 | 29 | | | of Whet Country? | |
| BAITIMORE, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperminent of Health and Mental Hyglene. Important: If them 27 is marked other than "natural", or frems 23s or 28s-f show any injury or other traumatic event, ir a Marcal Expriser mant be nutlind at | by Funeral | 11. Maritel Status 1 Never Marriad 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Evar in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: | ,S. 1 | | edent of I becify Cub 2X No | Hispanic Orlgin? (S en, Mexican, Puert Specify: | pecify Yes or No o Rican, atc.) | | Raca - Amarican In Black, Whita, atc. cifyBLACK | dian, |
| 5-0 72 hc 72 hc | Completed | 15. Decedent's Edu (Specify only highest gred | | 16a. De | ecedent's Us | uel Occup | pation during most of world) | kina | 16b. Kind of | Business/Industr | у |
| d 2121 filed within Hygiene. fther than ont, ire we | dm | Elemantary/Secondery (0-12) | College (1-4or 5+) | | | use retire | nd) | | DEC | TAURANT | 1 |
| Hed Sign | | 5th 17. Fether's Neme (First, Middle, Last) | N/A | CC | OOK | | 18. Mother's Ner | ne (First Middle | | | • |
| d be de de de de de de de de de de de de de | To Be | UNKNOWN | | | | | JOSEPH | | | | |
| Aarylan 2 should be 6 end Mental 1s marked o raumatic eve | F | 19a. Informent's Neme/Reletionship (T) | ype, Print) | 19b. M | eiling Addre | ss (Street | end Number or Ru | | | | e) |
| 1 end 2 Health e am 27 is wher tra | | HENRY DUNMORE/ | | | _ | | ON RD. | | | | -/ |
| altimore, mit. Pages 1 er pertment of Hea portant: If Itam. y injury or othe | | 20e. Method of Disposition 1) Transport 2 Cremation 3 F 4 Donation 5 Other (Specify) | Removel from State | emetery, o | sposition (Normalized Normalized | othar ple | VA CE | EP 10 1997 | | on - City or Town, S | |
| bemit. Page Department Important: If | -000e | 21. Signature of Guneral Service Licens | Low | | | | ess of Fecility BE | | NERAL BALTO, | | 1.3 |
| Street be sweated with the physician and ing physician and e es the buriel-fransit | Medical Examiner | Immediete Ceuse (Finel disaese or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in daeth) Last | b. Pinsett. Due to (c. Rend | or es e con for es e con Tagain as a con | sequence of sequence of sequence of | n: n cy): C | Juhos | | | | et and Deeth |
| death cert e attending of for use | sian | | | | | 1 | | | | | |
| . 0 0 2 | / Physician/ | Part II. Other eignificant conditions con | ntributing to death but not res | ulting in th | e underlying | causa gi | van in Part I. | | Yes 25-N | contribute to the | |
| cords requires been sign should be | Completed by | | | | | | | | en eutopsy ormed? | availebl | utopsy findings e prior to tion of cause 1? |
| The lay ate has page 2 | E O | | | | | | | 10 | Yes SON | 1 □ Yes | 2 No |
| VITAL I | Be | 25. Wes case referred to medical exeminer? | | | | | 26. Place of Dee | th (Check only | one) | | |
| Physic this c | 2 | 1□ Yes 3€ No | | ER/Outpe | | JUA | her: 4 Nursing H | | | Other (Specify) | |
| ling Filling F | io | 27. Menner of Death 127 Hateral 5 ☐ Pending | 28a. Dete of Injury (Month, Dey Year) | 28b. Time Injur | У | 28c. Inju Wo | | 28d. Describe | how injury occ | curred | |
| To the Hospital of Attending Physician: The Is within 24 hours effer deeth. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page | Certification: | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - At h building, etc. (Specif | ome, farm, | M straat, facto | | Yes 2□No | 28f. Location (City or To | | mber or Rurel Rou | ite Number, |
| To the Hospital within 24 hours To the Funeral completely filled | edical C | 29a. Certifier 1 Certifying Physics (Check only one) 2 Madical Exami | sician: To the best of my kno ner: On the basis of examine end menner steted. | wledge, de tion and/or | eath occurre Investigetion | d et the ti | me, dete end plece opinion, deeth occu | , end due to the rred et the time, | cause(s) end date end pled | menner es steted. a, end due to the | ceuse(s) |
| To th Withir To th | Me | 29b. Signature end title of certifier | | | 2 | 9c. Licens | se number | | | ned (Month, Dey, | Year) |
| | | Bonne El. | den ma | | | 0417 | 197 | | 9/9/9 | 7 | |
| A d | | 30. Name and eddress of person who co | | 123e) (Typ | pe, Print) | Bul | hmon v | 10 21 | 204 | / | |
| | State | 31. Dete filed (Month, Day, Yeer) SFP 1 1 1007 | 32. Registrer's Signe | ture | | | | | | | |



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State of Maryland / Department of Health and Mental Hygiene 97 271,79

| | | | ITEM: 8 per FH G-751 9 | | arylaria / | Certificate of | | Reg. | | 614 | 13 |
|---------------------|---|-------------------|---|--|---|---|---|---|-----------------------|--|-----------------------------|
| | Physici /Medic | | 1. Decedent's Neme (First, Middle, L | emetrice | | - 1 | | 2. Date of Deeth | Dey Y | 3. Time | e of Death |
| | Examir Funeral | | 4e. Fecility Neme (If not institution, g. Sing Hospital) 5. Social Security Number 6. | ve street and number) | | irthday) If Under 1 Ye | | cation of Deeth C MD 8. Date of Birth (Month, Dey, Ye | 4c. County of Batti | Deeth MOFE C 9. Birthplece (State Country) | te or Foreign |
| | Director | | Usuel Residence of Decedent | 100 W 201 | 80 | Yrs. | | 08/26/1 | 909 | Creece | 2 |
| | Menylan H show | tor | Md. Balts | more | | on or Location | | | | | e City Limits Yes 2 No |
| | th with the 23a or 28a | al Director | 10e. Street and Number 4615 Park Heigh | nts Ave. | | 10f. Zip Cod | | 10g. | Citizen of Wh | net Country? | |
| 020 | 72 hours after death with the Meryland natural", or items 23a or 28s-f show olds! Examine must be notified at | by Funeral | 11. Meritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Wes Decedent Armed Forces? 12 Yes 2 If Yes, Give Yeer or Deles: | No | 13. Was Decedent of II Yes, specify C | of Hispenic Origin? (Spe uban, Mexican, Puerto I No <i>Specify:</i> | cify Yes or No- Rican, etc.) | | American Indien White, etc. White | 19 |
| Maryland 21215-0020 | 5 9 | Completed | 15. Decedent's E (Specify only highest given the second of | ducation | 166 | | cupation ne during most of worki lired) | ng | | iness/Industry | Plan |
| d 2 | 등문학부 | | 17. Fether's Neme (First, Middle, Las | t) | 7 | /endor | 18. Mother's Neme | S€ | elf emp den Sumeme | | |
| lan | bed be | To Be | Unknown | | Demetr | iou | | nknown | • | nknown | |
| lary | end end s m | - | 19s. informant's Neme/Reletionship | (Type, Print) | 19 | b. Meiling Address (Str | eet end Number or Rura | l Route Number, Cit | y or Town, S | tete, Zip Code) | |
| | Heelt Ta 2 | | Green Spring Nurs 20e. Method of Disposition | | 20b. Plece | 515 Park He of Disposition (Neme of | eights Ave. | | | 21215 ity or Town, State | • |
| Baltimore, | permit. Peges 'Depertment of H important: If its any injury or ot | | 1 DBurlel 2 Cremetion 3 4 Donetion 5 Other (Spec | (h) | | son Forest 22. Name end Ad | Vetrans 9, | | | Mills, | Md. |
| | Physician | | 23e. Pert1. Enler the disease, or cor shock, or heert feilure. List only | nplications thet caused one ceuse on each li | d the deeth. Do | not enter the mode of | k Rd. Towso | on, Md. 22 r respiretory arrest, | 1204 | | mete Between nd Deeth |
| | /Medical Examiner | er | Immediate Cause (Final disease or condition resulting in deeth) | · U | Due to (or es e | consequence of): | - | | | 1-2 | days |
| x 68760, | certificate be executed ding physician and se es the burief-trensit | /Medical Examiner | Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Lest | b | | consequence of): | | | | | |
| .O. Box | requires that the death cert seen signed by the attendin hould be detached for use | Physician/N | Pert II. Other significent conditions | | ut not resulting | in the underlying cause | given In Pert I. | 21 313-17-17-17-00 | | ributs to the caus | |
| σ. | es that igned b | by Pr | | | | | | 1 Yes | 2500 3 | Probably 4 | Unknown |
| Records, | 2 S S | Completed | | | | | | 24e. Wes en eu performed | | 24b. Were eutope eveileble pri completion of deeth? | or to |
| | ate h | Con | | | | | | 1 ☐ Yes | 200 No | 1 ☐ Yes 2 | 20 No |
| Vital | ysician: The | Be | 25. Wes case referred to medical exeminer? | Hospitel: | | | 26. Place of Deeth Other: | | | | |
| o | Phys ral di | ion: To | 1 Yes 2 100 27. Menner Deeth 1 Neturel 5 Pending | 28e. Dete of Inju | ry 28b. | Time of linjury 28c. In | njury et 2 | ne 5 Residence 28d. Describe how in | | | |
| Division | or Atten effer deal Director: in by the | Certification: | 2 Accident investigation 3 Suicide 6 Could not determined | 28e. Plece of Inj | ury - At home, f c. <i>(Specify)</i> | arm, street, factory, offi | Yes 2 No | 28f. Location (Street City or Town, St | | or Rurel Route N | lumber, |
| | Hospits Fineral | edical C | 29a. Certifier 1 Certifying P (Check only one) 1 Madical Exa | hysician: To the best miner: On the basis o end manner st | examination er | e, deeth occurred et the nd/or Investigation, in m | e time, dete end plece, e ny opinion, deeth occurre | and due to the cause ad at the time, date | end plece, en | ner es steted. Id due to the ceus | ie(s) |
| | 111 | | 29b. Signeture end title of certifier | | | 29c. Lic | ense number | 29d. | Dete signed (| (Month, Dey, Yea | r) |
| | 4 | 9 | anthons | 1. 130 | our | M.D. AS | 2402321A | 39814 Se | ptem be | 8, 10 | 197 |
| | 6 | | | Burns M. | D | Singi Ho | spital of | | | , | |
| | Sta Registr | | 31. Dete filed (Month, Bay, Year) SEP 1 1 1997 | 32. Registr | er's Signeture | ell, | | | | | |

97-5017-510 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. CIP State of Maryland / Department of Health and Mental Hygiene 27480 RONALD D. EVANS Items:233 part 27,28a-f per MEO G-751 9/16/97 dh Certificate of Death 2. Dete of Deeth SEPTEMBER 3, 1997 **Physician** 7:30AM RONALD D EVANS /Medical 4e. Feclity Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner BALTIMORE.
If Under 24 Hrs.
Hours Min.
SEP 12,] IN REAR OF 2856 HARFORD ROAD If Under 1 Year Birthplece (State or Foreign Country)
 MD Social Security Number Age (In yrs. last birthday) **Funeral** 1□**X**0 2□ F Deys 219-66-7390 Yrs. 40 Director 1956 Usuel Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show MD N/A BALTO traumatic event, the Medical Examiner must be notified YOYes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ö 9816 TOLWORTH CIRCLE Itams 23e 21133 U.S.A. Funerai 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X Yeer or Detes: 1 Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 8 1 ☐ Yes 2 ☑ No by Specify: BLACK 3 Widowed 4 Divorced *naturel', Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) markad other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiena CITY 12th N/A MAINTENANCE WORKER ent of Health and Mental Hy, 1: If Item 27 is marked 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be WILLIAM EVANS SYLVIA BOONE 19e. Informent's Neme/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 133 PATRICIA PENDER 9816 TOLWORTH CIRCLE RANDALLSTOWN, 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) SEP 8 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) permit. Page Department o Important: If any Injury or ARBUTUS MEM PK 1997 ARBUTUS, MD 22. Name and Address of Facility BETTS FUNERAL HOME 1129 N. CAROLINE ST BALTO, MD 21213 ucla Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Intervel Between Onset end Death **Physiclan** /Medical Immediate Cause (Final diseese or condition resulting in death) NARCOTIC INTOXICATION Examiner Due to (or es e consequence ot): Examiner that the death certificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting in death) Lest Due to (or es e consequence of): Box 68760 Physician/Medical the Due to (or es e consequence of) Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contributa to the causa of death? 2 1 Tyes 2 No 3 Probably 4 Unknown signed i Records, by 24b. Were autopsy findings eveileble prior to completion of ceuse of deeth? Completed 24e. Was en eutopsy performed? peen Yes 2 No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director, Be 25. Wes case reterred to medical exeminer? 26. Piece of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 X Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA IN ALLEY 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending 1 Naturel 2**XX**No Investigation 1 Yes 2 Accident found 9/3/97 unknown unknown 6XXCould not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 - Homicide Your Street To the Funeral Dir unknown Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end pleca, end due to the ceuse(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number

State

State Registrar

32. Registrer's Signeture

Julia Auridson-Randelle

end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

O.C.M.E.

SEPTEMBER 3, 1997

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 7, SEPT. 1997 4:32pm ROSLYN HTLDA /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner HOWARD COLUMBIA HOWARD COUNTY GENERAL HOSPITAL 7. Aga (In yrs. lest birthdey) If Undar 1 Yaar If Under 24 Hrs. Months Deys Hours Min. MARCH 9,1918 5. Sociel Security Number 9. Birthplece (Steta or Foreign **Funeral** 1 □ M 2 F NEW YORK Director 133-03-9204 Usual Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits COLUMBIA 1 Xas 2 No Director MARYLAND HOWARD 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21044 4989 COLUMBIA RD., APT. 102 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forcas 2, 1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian, Bleck, White, etc. 1 Never Marriad 2 Married 1 Yas 2 No Specify: WHITE þ 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collaga (1-4or 5+) OWN HOME HOUSEWIFE 12 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be KAPLAN COHEN MARY MORRIS 19a. Informant's Name/Retetionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) MRS. LINDA NADELBERG (DAUGHTER) 4989 COLUMBIA RD, APT. 102 COLUMBIA, MD 21044 20b. Plece of Disposition (Neme of cematary, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Ramovai from State 9-9-1997 HUNTINGTON STATION, N.Y. 4 ☐ Donation 5 ☐ Other (Specify) MT. GOLDA 22. Name and Addrass of Facility Sol Levinson & Bros., Inc. 8900 Reisterstown Road Pikesville, MD 21208 caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, each line. Approximeta Intervel Batween Onsat and Deeth **Physician** /Medical ru ta Ceu a (Final coppe Examiner Dua to (of as a consequence of): Examiner sotensio Sequentially list conditions, if eny, laading to immedieta cause. Entar Underlying Ceuse (Diseese or Injury that initiated evants resulting in deeth) Lest or es a consequance of) estive Heart Physician/Medical Due to or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown gullable State þ 24b. Were autopsy findings evelleble prior to completion of cause of death? 24a. Wes en autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Julmonary 25. Wes case rafarred to medical exeminer? Be 26. Piece of Deeth (Check only ona) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Residenca 6 Other (Specify) 2 1 Yes 2 No 28e. Dete of Injury (Month, Dey Year) 27. Mennar of Deeth Certification: 28c. Injury et Work? 28d. Dascribe how Injury occurred 1 Auturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accidant 8 Could not be determined 28f. Location (Streat end Number or Rural Route Number, City or Town, Steta) 3 ☐ Suicide 28e. Placa of Injury - At homa, ferm, straat, factory, offica building, etc. (Specify) 4 Phomicida 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceusa(s) and mannar es stated.

2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the causa(s) end menner stetad. 29a. Certifier Wedical

28a-f show

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Items 23a

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Box 68760

P.O.

Records,

Division of Vital

Attending

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hours al uneral Di

72 hours after

Baltimore, Maryland 21215-0020

traumatic event, the Medical Examiner must be notified at

DR. STEPHEN GEORGE 31. Date filed (Month, Day, Year) SEP 1 1 1997 State Registrar

(Check only one)

29b. Signature and title of certifier

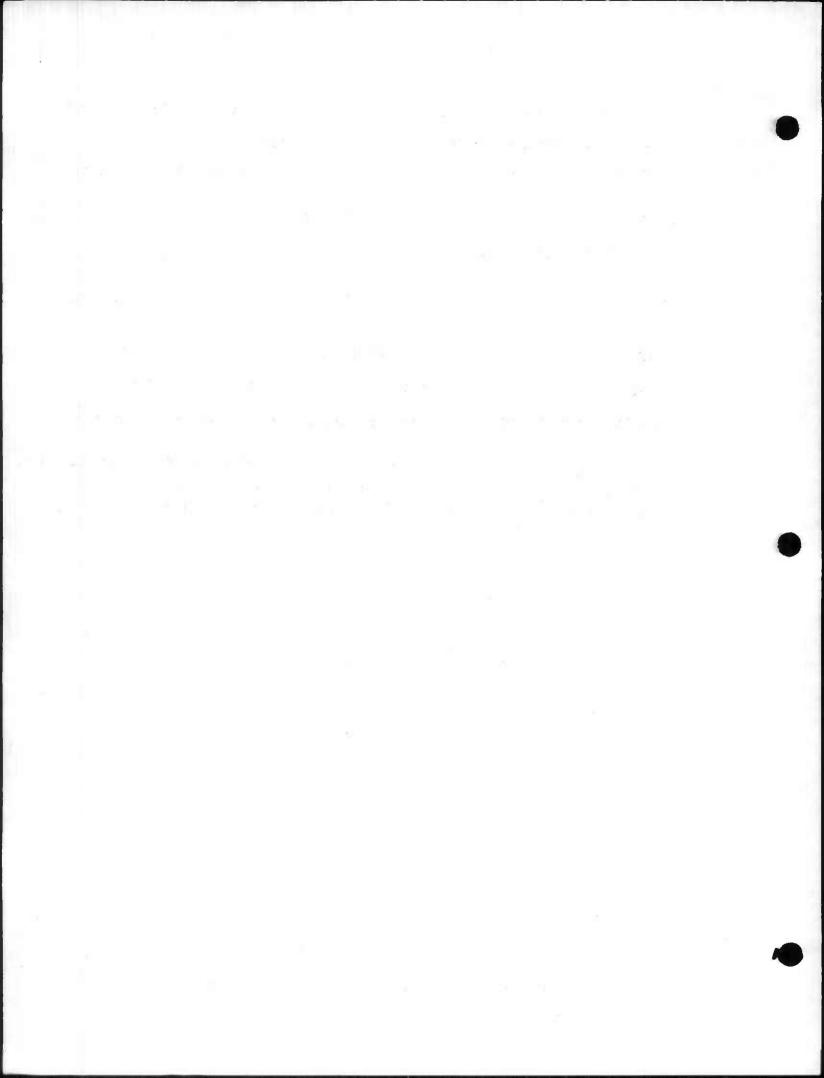
30. Name and addrass of person who completed cause of death (Item alse) (Type, Print)

4801 DORSEY HALL DRIVE, #226 ELLICOTT CITY, MD 21042 32. Re Alsyar's Signature
Fukar Daydson-Randelle

29c. License number

D 43195

29d. Data signed (Month, Dey, Year)



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

29d. Dete signed (Month, Dey, Year)

September 10,1997

4940 Eastern Ave., Baltimore, Md 21224

271.02

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| Director | r | 548-49-6486 | IND M ZLIF | 27 | Yrs. | | | | | 5-15- | 1970 | | Conn. | | | |
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| a-f shov | ctor | MD 10a. Stete 10b. County | n/a | | | | | | | | | 10d. Inside City Limit | | | | |
| filed within 72 hours efter death with the Merylend Hygiene. ther than "natural", or Itema 23a or 28a-f show but, the Medical Examine must be notified at | Funeral Director | 10e. Street and Number 3633 Robert | 10f. Zip Code 21224 | | | | | | 10g. Citizer | hat Country? USA | | | | | | |
| s i entre a stroute beneve within 7.2 hours enter bestriwith the meryter Health and Mental Hygiene. I Health and Mental Hygiene. I health and Ked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Examples must be notified at | by Funer | 11. Meritel Status 1 Never Merried 2 Marria 3 Widowed 4 Divorced | ried 1 ☐ Yes | 2 No ve | | Wes Deceden If Yes, specify 1 Yes 2 | | panic Origin Mexican, I Specify: | ? (Spac Puerto F | city Yes or No lican, etc.) | | | - American Ir k, White, etc. Whit | | | |
| aftura | B | 15. Deceden | 16e. Dece | Decedent's Usuel Occupation | | | | | 16b. Kind of I | | | Business/Industry | | | | |
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| and Mental Hygiene. | To B | Robert E. En | merson | son | | | | | | Karen F.Ste | | | einherger | | | |
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State Registrar 29b. Signeture end title of certifier

31. Dete filed (Month, Dey, Year) SEP 1 1 1997

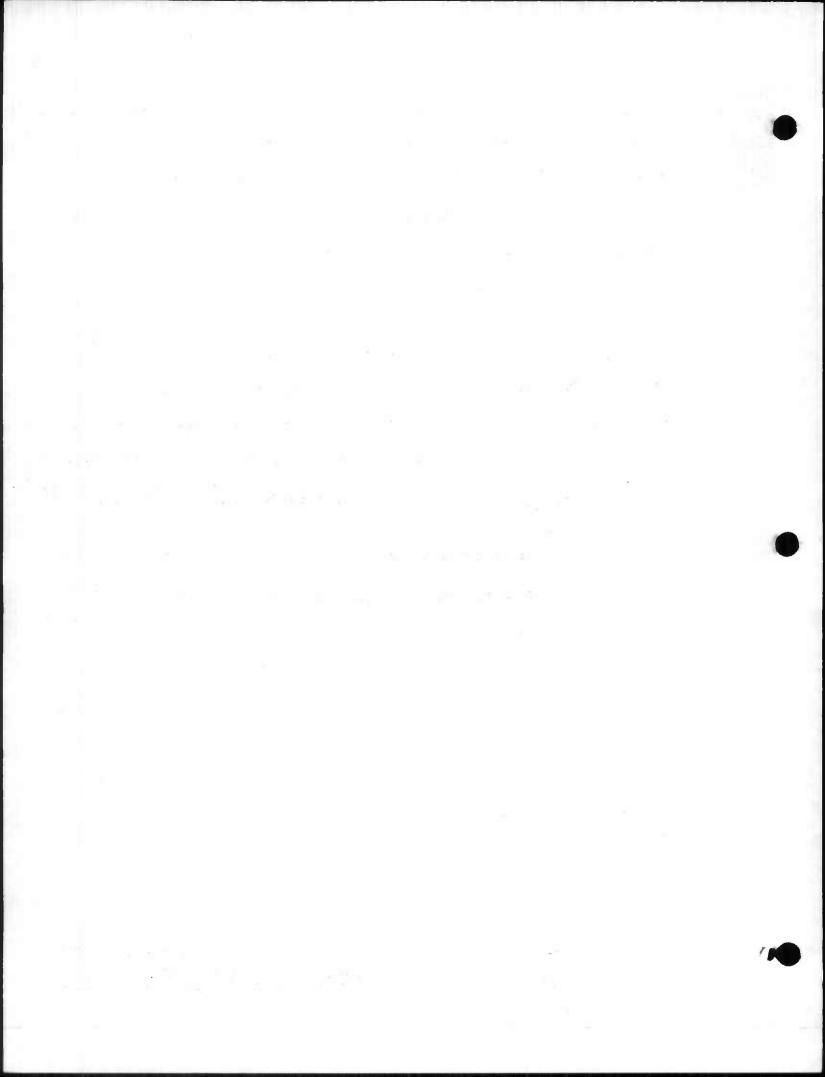
Ann E. Smith

MD

29c. License number

30. Name end eddress of person who completed ceuse of death (Item 23e) (Type, Print) Johns Hopkins Bayview Medical Center

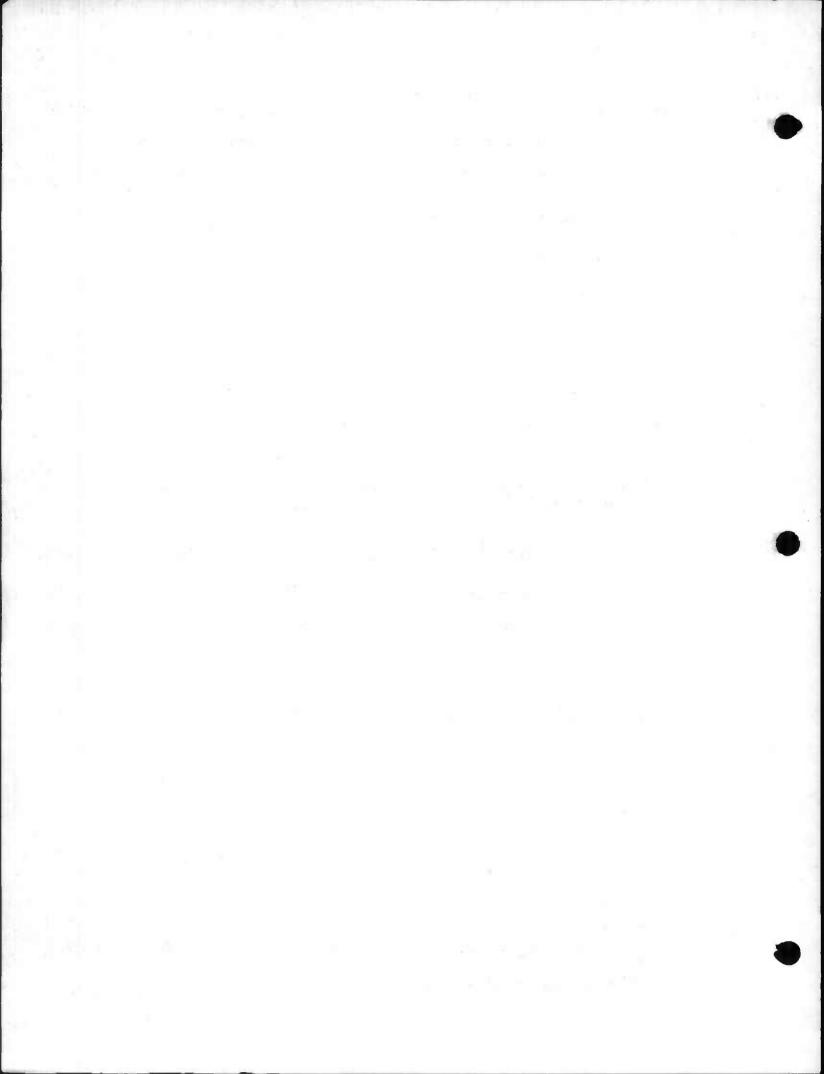
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State of Maryland / Department of Health and Mental Hygiene 97 27483

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| Physician /Medical Examiner | | Decedent's Nama (First, Middle, Last) | | | | | | | 2. Date of De | | | | 3. TI | me of Death | | | |
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| | | 5. Social Security Number | 6. Sex | | 7. Age (In yrs. lest) | birthday) | If Under 1 Y | | | 24 Hrs. | 9 Date of Birth 9 Blathele on (Ctos | | | | | itete or Foreid | |
| Director | | 220-24-3682 | Months Days Hours | | | | | | | Min. | (Month, Dey, Yeer) Country) | | | | | | |
| | | Usual Residence of Decedent | - 41 | | 00 | | | | | | Sep 9 28 USA | | | | | - | |
| Maryland | | 10a. State 10b. Count | 1 | | 10c. City, To | wn or Lo | cation | | | | | | | | 10d. Ins | Ida City Limit | |
| | ō | MD Howard Elkridge | | | | | | | 1 ☐ Yes 2 ☐ No | | | | | | | | |
| tha 28s | Director | 10e. Street and Number 10f. Zip Code | | | | | | | T | 10g. Citizan of What Country? | | | | | | | |
| 72 hours after death with the Maryland "naturel", or frems 23e or 28a-f show added Exeminer must be notilled at | | | | | | | | | | | | | | | | | |
| | era | | | | | | | | | | JSA | A . Race - American Indian, | | | | | |
| Fer de | Funerai | 11. Marifal Sfatus | / | 12. Was Decedent Ever in U.S. Armed Forces? | | 13. 1 | Was Dacedant of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert | | | n, Puerto | Rican, etc.) | Black, Wh | | | | an, | |
| d within 72 hours aft giane. r than "naturel", or I | by F | 1 Never Married 2 Ma | . | I ☐ Yas If Yes, Giv | /e | 1 ☐ Yes | | | es 212 No Specify: | | | | Specify: white | | | | |
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| | Co | 10 | | | | Co | ppersm | ith | | | Beth. Steel | | | | | | |
| 0 = 0 5 | Be | 17. Father's Name (First, Middle, Last) | | | | | | er's Nam | ame (First, Middle, Meiden Surneme) | | | | | | | | |
| | 2 | Edward P. Falter Anna | | | | | | na G | Gasper | | | | | | | | |
| 2 sho and Is me | Ι. | 19e. Informent's Name/Relation | ship (Type, I | Print) | 1 | 9b. Meilir | ng Address (St | treet e | nd Numb | er or Ru | Rurel Route Number, City or Town, Stete, Zip Code) | | | | | | |
| | | Mildred M. H | alter | | | 616 | I Eval | | 7 | | TOT least of a | | m 2 | 1075 | | | |
| t. Pages 1 rtment of Hi rtant: If Iten | | 20a. Method of Disposition | urcer | | 20b. Place | of Dispo | sition (Neme o | LU - | Aven | ue, | Elkridg | 20c. L | ocation - | City or To | own, Sfa | ata | |
| | | 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (| | val from | State | | ge Memo | | , | h- | 9/8/97 | ווס | rwi d | ge, M | ATT) | | |
| | | 21. Signature of Funeral Service | | | * icado | | . Name and A | | | | 3/0/3/ | EIL | ZT TO | ge, r | עני | | |
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| 401.0 | | Jeven | KW) | W. | | 00 | Me Me | emo | rial | Par | k Inc | me c | IC PR | Eadow | VI IU | ge | |
| Physician /Medical | П | 23a. Pert1. Enter the disaase, of shock, or heart failure. Lis | r complication | ons that c | aused the death. D | o not ent | er the mode of | dying | , such as | cardiac | or raspiratory a | rrast, | | 1 | Appro | xlmete al Between | |
| | | | | | | | | | | | | | | | Onset | and Death | |
| | | find disease or condition resulting in death) a. Acute Myscardial infarction Due to (or as a consequence of): Athero Sclerotic Cardio Vascular Disease Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | MI | day | | | | | |
| Examiner | | resulting in death) | a. 1 | 100 | Due to for ea | TU | worse off: | | | 1117 | all | COI | 7 | 1 | UIU | | |
| | ě | | / | 1 1 | 70 C | 200 | F. | | li | 11- | . 1 | Α 1 | | 100 | 10 | | |
| uted ansit | 盲 | | 6. F | FINE | no see | UW | 112 | an | are | va | scurar | 01/ | gea | N | 10 | 7y | |
| ertificate be executed ling physician and e as the burlet-transit | Examiner | if eny, leeding to immediate | | 2 | Due to (or es | e conseq | 1 / 1 | 1. | 1 | | | | | 1 | | | |
| sicia bur | | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events | | | | | | | 7 | | | | | 10 | pro | | |
| phy s the | Medical | rasulting In death) Last Due to (or as a consequence of): | | | | | | | | | 1 | V | | | | | |
| | 3 | | d | | | | | | | | | | | | | | |
| eath c attend for us | by Physician | | | | | | | | | | | | | | | | |
| s that the d gned by the | ysic | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 1. | 23b. Dld | 23b. Did tobacco use contribute to the cause of c | | | | | | | |
| | P | Peripherel Vascular déseas | | | | | | | , | 10 | 1 Yes 2 No 3 Probably 4 | | | | | | |
| | by | reapport | | - | -uwaz | | | | | | | | | | | | |
| | Completed | | | | | | | | | | 24e. Was | an auto | psy | | ere auto | opsy findings prior to | |
| | ple | | - | | _ | | | | | | | | | | omplefio death? | n of cause | |
| 0 - 5 | E | | | | | | | | | | 10 | Vac 2 | A No | 41 | □ Vaa | 2 No | |
| ital or Attending Physician: rrs after death. rel Director: After this certifii iled in by the funeral director | | 25 Was seen referred to medias | | | | | | | | | | | ACT IAO | | 162 | 2 LI NO | |
| | o Be | examiner? | | | | | | | | ath (Check only one) | | | | | | | |
| | - | 1 Inpatient 2 DE ER/Outpatient 3 I DOA 4 I Nursing I | | | | | | | | ursing Ho | ome 5 Resi | | | | fy) | | |
| | lon | 1 ★ Naturel 5 □ Pending (Month, Dey Year) fnjury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No | | | | | | | | | 28d. Describe | now inju | iry occur | red | | | |
| | cat | | | | | | | | | | | | | | | | |
| | Certification: | | | | | | | | | Location (Street end Number or Rurel Route Number, City or Town, State) | | | | | | | |
| | Ce | | | | | | | | | | | | | | | | |
| | cai | 29a. Certifier (Check only (Check only and due to the cause(s) and manner as stated. (Check only a Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) | | | | | | | | | (2) | | | | | | |
| | edicai | one) | CASIMIRSI. | and man | ner stated. | and/or inv | restigation, in i | шу ор | irnon, des | un occur | red et the time, | gate an | a place, | and due t | to the ca | luse(s) | |
| To To | Σ | 29b. Signature and title of certifie | 9b. Signature and title of certifiary 29c. Licansa number | | | | | | | | | d (Month, Day, Yeer) | | | | | |
| | | /san | Car | an | | | D. | 21 | 649 | 7 | | Sei | 6 | 5 | 19 | 97 | |
| | | 20 Name of 1111 | | | - 4 4- 4 42 |) (TP | D (10) | | C 1 | - | | | | | | | |
| 0 | | 30. Name and address of person | wno comple | Pred caus | e of deeth (Item 23s | i) (Type, | Print) | F. | K | 4/5 | RAI | TIL | 100 | EX | 40 | 2 (1 2 | |
| | | | DITS | N | VNV, 54 | 22 | WILK | LH | 13 / | VD | . /5., - | , ,, | ·UICI | / | '9' | 112 | |
| | ate | SEP 1 1 1997 | 1 | 32. A | gistrar's Signature | 182 | | | | | | | | | | | |
| Regist | rar | OFL + T 122/ | | | he larrest a by the | - | | | | | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Dete of Death 3 Time of Death Dev eptember 3, FLORENCE C. FIELDS 0735 Am 1997 4e. Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Deaton University of MD. Medicine BalTimore Hours Min. 8. Dete of Birth (Month, Day, Y) If Under 1 Year 5. Societ Sacurity Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthpleca (State or Foreign Country)
VIRGINIA Months 1□M 2□F Days 73 229-36-6444 Usuet Residence of Decedent 10e. State 10b. County 10c. City, Town or Locetion 10d. Inside City Limits 1 Yes 2 □ No BALTIMORE MD. N/A 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1701 EUTAW PLACE 21217 USA APT. # 1010 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yas or No-tf Yas, specify Cuben, Mexican, Puarto Rican, atc.) Raca - Amarican Indien, Biack, White, etc. 1 Never Married 2 Married AFRICIAN AMERICAN 1 ☐ Yes 2 No Specify: 3 ☐Widowed 4 ☐ Divorced Yeer or Detast 16a. Decedent's Usual Occupetion (Giva kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) COOK RESTAURANT 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) CHARLES HARPER SARAH HARPER 19e. tnforment's Name/Raietionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LISA HOFFMAN (GRANDDAUGHTER) 3512 NAYFAIR RD. BALTIMORE, MD. 21207 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cramation 3 Removel from State ARBUTUS CEMETERY 9-8-97 ARBUTUS, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility ESTEP BROTHERS FUNERAL HOME 1300 EUTAW PL. BALTIMORE, MD. 21217 es 23a. Pert1. Subar the disaese, or complications that caused the daath. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or hear failure. List only ona cause on each line. Approximate Intervei Between Onset and Death immediate Ceusa (Final disease or condition rasulting in deeth) Acute My CARDING INFARCT CARDIOUMSCULAR DISERSE Sequentially tist conditions, if any, laading to immediata cause. Enter Underlying Cause (Diseasa or injury that initiated avants rasulting in deeth) Last Dua to (or es e consequance of): Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Dtd tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Minknown CANDIDA FUNGINEA. SEPSIS. 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? CORON HAY ARTERY 200No 1 ☐ Yes 2 KNo GRAFT 1 Tes 25. Wes case referred to medical axeminer? 26. Ptace of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Munpatient 2 □ ER/Outpetient 3 □ DOA 27. Mennar of Deeth Dete of tnjury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 1 Naturet 2 Accident 5 Panding Investigation 1 Yes 2 No 6 Could not be datermined 3 Suicide 28e. Plece of tnjury - At home, ferm, streat, factory, offica building, atc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicida

Examiner P.O. Box 68760, 1-LONENCE

The law requires that the death certificate be executed Division of Vital Records,

ettending physician end for use es the burial-tran director, page 2 should be certificate hes this

Physician

/Medical

Examiner

Director

Funerai

by

Be Completed

Funeral

Director

show

r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after nent of Health end Mental Hygiene.

Hygiene.

other traumatic event,

Important: If item 27 Is any injury or other tra once.

Physician /Medicai

by Physician/Medical Examiner

Completed

Be

2

Certification:

Medical

29a. Certifier

(Check only one)

85

s efter oc... ral Director: After ... by the funeral of or Attending Hospital 24 hours 8 To the Hosp within 24 hor To the Fune completely fi

> State Registrar

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion end/or invastigetion, in my opinion, deeth occurred at the time, data end place, end due to the cause(s) end menner stated. 29c. License number

29b. Signature end titla of certifier James P. G. tapur les

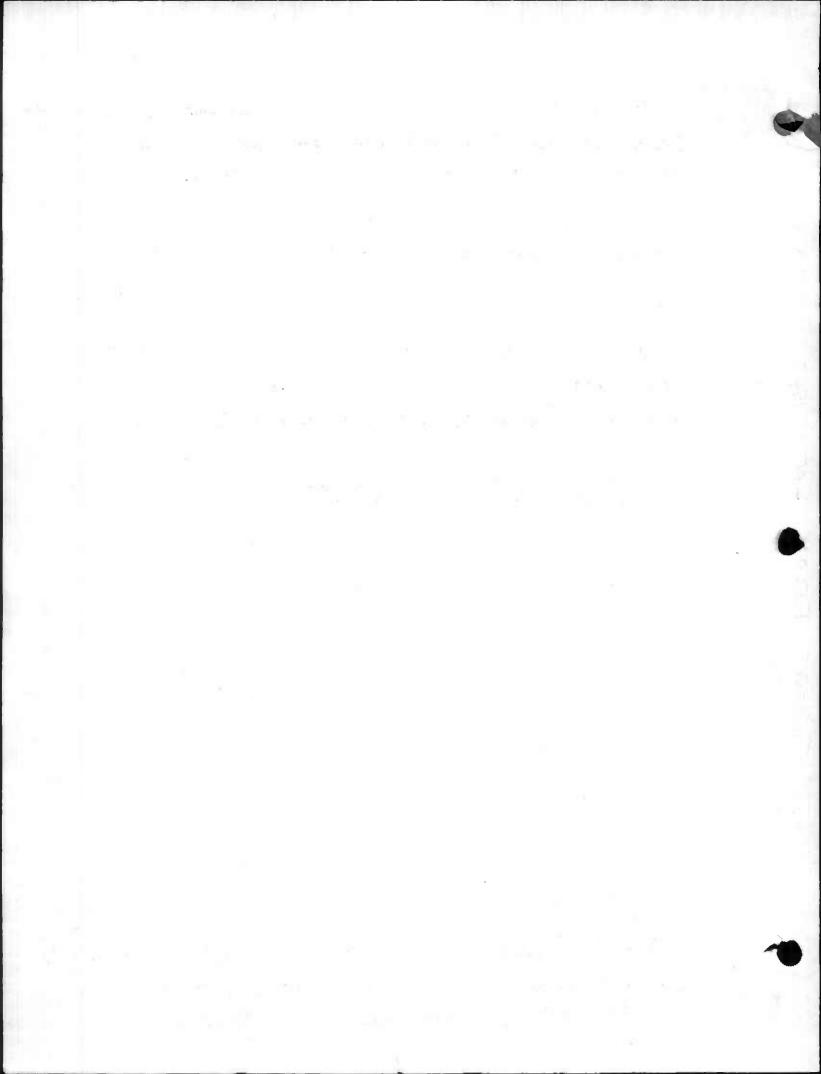
29d. Dete stgned (Month, Day, Year)

30, Name end eddrass of person who completed cause of daath (Item 23e) (Type, Print)

FLYNN WO S. CHARLES HHES P. DESTON HOSPITAL

31. Dete fited (Month, Day, Yaar) SEP 1 1 1997

32. Re Strar & Signature



State of Maryland / Department of Health and Mental Hygiene 97

97 27485

| | | | | | | Certifica | te of | Death | | Reg. No. | | |
|------------|--|---------------|--|---|------------------------------|---------------------------------------|--------------------------------------|--|--|-----------------------------------|-------------------------------------|---|
| | Physic | | 1. Decedant's Neme (First, Middla, Las | " <i>J</i> . | Gai | ney | | | 2. Dete of Do Month SEPTEM | eeth Dey | Year 1997 | 3. Time of Deeth 6:00PM |
| 9 | /Medi Exami | | 4e. Facility Nama (If not institution, give | street and number) | (1 | 1109 | | 4b. City, Town, o | r Location of Deel | - | | 0:00PM |
| | | | THE JOHNS HOP | KINS HOSPI | TAL | | | BALTIMO | | | | |
| | Funeral Director | | 5. Social Security Number 251-14-0178 Usuel Residence of Decedent | 7. Age | (In yrs. last bii 76 | Yrs. If Und Month | ar 1 Year Deys | If Under 24 Hi Hours Mi | | ay, Yaar) | 9. Birthp | slece (State or Foreigntry) 5 ° C , |
| | the Maryland 28a-f show | tor | 10a. Stete 10b. County | | 10c. City, Tow Ba | m or Location Himon | 2 | | | | 1 | 0d. Insida City Limits |
| | th with the 23a or 28a | ai Director | 10e. Street end Number | ntford | Ave | 10f. 2 | ip Code | 213 | | 10g. Citizen of | What Cour | itry? |
| מסח | 72 hours after death with the Maryland natural; or items 23a or 28a-f show preal Examiner must be notified at | by Funeral | 11. Maritel Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced | 12. Wes Decedant Ev Armad Forces? 1 Yes 2 No if Yes, Give Yeer or Datas: | | 13. Wes Dec | ecify Cub | dispanic Origin? (en, Mexicen, Pus Specify: | Specify Yas or Norto Rican, etc.) | | ce - Amaric ck, White, by: 13 | |
| 71213-0020 | d within piena. r than " | Completed | 15. Dacedent's Ed (Specify only highest grad Elamantery/Sacondary (0-12) 3rd grad | | 16e. | | uel Occup rork done usa retire | pation during most of w d) | orking | Sme Hin | | Ce fining Co. |
| Mal ylaild | d 2 should be filed the and Mentel Hygis I is marked other traumatic event, it | To Be | 17. Father's Neme (Pirst, Middle, Last) UNKN | | | | | 18. Mother's N | eme (First, Middle | , Maiden Sumai Brac | | d |
| 3 | T les | · | 19a. Informent's Name/Relationship (7 | iype, Print) INUS | 196 | . Meiling Addra | | ^ | d Ave | | | |
| | Pages 1 and 2 nent of Health nt: If item 27 I iry or other tri | | 20a. Method of Disposition 1 | Removel from Steta | cemate | f Disposition (Nry, crematory of | eme of other pla | | Date | 20c. Location | - City or To | own, Stete |
| | permit. Pag Department Important: II eny injury o | | 4 Donetion 5 Other (Specify, 21. Signeture of Funarel Service Licens | | WEST | | and Addre | CEM ess of Facility | 9-12-97 | Catons | | |
| | 20200 | | 23a. Pert 1. Entar the disease, or comp | lications that caused to | ha daath. Do | Mar not enter the mo | | 17. 0 | - | | Nort | th Ave |
| | hysician /Medical | | shock, or heert feilura. List only o | | | oronchi | <i>T</i> , c | | | | | Interval Between Onsat and Death |
| | Examiner | L | diseese or condition rasulting in death) | | | consaquance o | | | | | | week |
| 1 | uted d ansit | Examiner | | b. Chi | ronic c | consequence of | CHIVE | - pulma | nary d | isease | | years |
| 60000 | certriceta be executed ding physician and se es the bunel-transit | /Medical Exa | Sequentielly list conditions, if any, leading to Immediate ceuse. Entar Underlying Cause (Disease or Injury that initiated events resulting in daeth) Lest | c | etasta | | osto | ite car | cer | | | years |
| 2 | 63 | an/Me | Ĺ | d | | | - | | | | | |
| | requires that the death een signed by the atte hould be detached for | Physician | Pert II. Other significant conditions co | ntributing to death but | not resulting in | n the underlying | ceuse giv | van in Part I. | | tobacco use co | | the cause of death |
| | as 2 S S S S S S S S S S S S S S S S S S | Completed by | | | | | | | 24a. Was part | en eutopsy ormed? | ev | ara autopsy findings allabla prior to mpletion of ceusa daath? |
| | Page Page | | 25. Was casa raferred to medical | | | | | | 2 | Yes 2□No | 10 | Yes 2 No |
| | | o Be | exeminer? | Hospital: | 2 □ ER/Ou | utpetient 3 0 | Ott | ar | aath (Check only Home 5 ☐ Ras | | nos /Consil | .1 |
| | The state of the s | tification: T | 27. Manner of Death 1 Statural 5 Pending 2 Accident Investigation | 28a. Dete of Injury (Month, Day | 28b. | Time of Injury | 28c. Inju | | T | how injury occur | | 0 |
| | or Alland The death Director: | Sentifica | 3 Suicida 6 Could not ba 4 Homicida detarmined | 28e. Place of Injury building, etc. | y - At home, fe (Specify) | erm, streat, facto | ry, office | | | (Street and Numi wn, Stata) | ber or Rura | i Route Number, |
| | V. | edicare | 29a. Cartifier (Check only one) Medical Exami | eician: To tha best of Iner: On the basis of a end mennar state | xaminetion en | a, daath occurre d/or investigetio | d et the tii n, in my c | ne, data end pled optnion, deeth occ | e, end due to the curred at the time, | ceusa(s) and m dete and place, | enner es si and due to | eted. tha ceusa(s) |
| | withir To the | Me | 29b. Signature end title of certifier | | | 2 | | e number | | 29d. Data signe | | |
| | | | | Wullek | | /Tuna Drint | RE | s-000 | 0 | Septem | ber i | 7,1997 |
| | | | 30. Name and addrass of person who o | omplated cause of dee | | | Rul | timore | M | vulanc | 1 2 | 1287 |

Registrar

DHMH 16 Rev 6/95

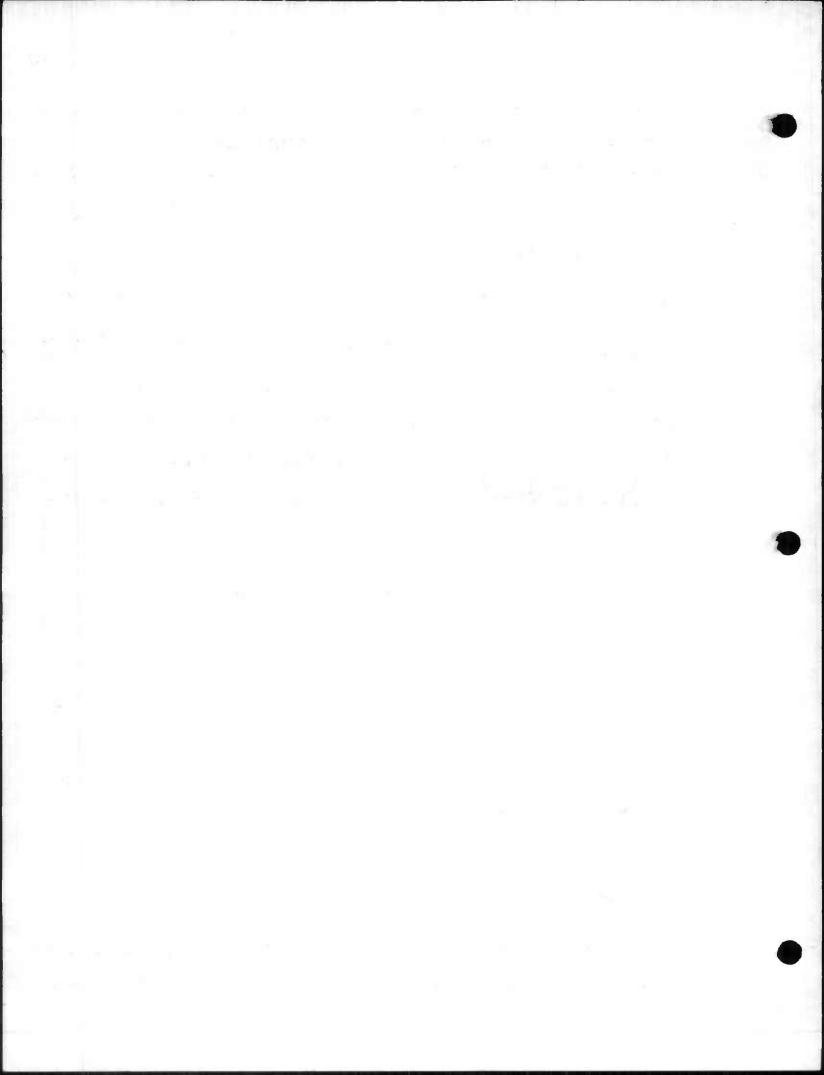
State

DEP 11 196

31. Dete filed (Month, Day, Year)

32. Registrer's Signetura

fulla Davidson-Randant



Peges 1 and 2 should be filed within 72 hours after nent of Health and Mentel Hygiene. Int: If Item 27 Is marked other than "natural", or ite

Baltimore, Maryland 21215-0020 permit. Peges 1 and 2.
Department of Health as Important: If Item 27 is eny injury or other trau **Physician** /Medical Examiner physician and the bunal-trans P.O. Box 68760. á Records, peen certificate Division of Vital To the Mospital or Attending Physician: within 24 hours efter death. To the Funeral Director: After this certific á

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** Month Year TREEN HAM /Medical 4a. Facility Name (If not institution, give street end number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BON SECOURS HOSPITAL BALTIMORE N/A Hours Min. FEB. 19, Year 44 If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthdey) 9. Birthplece (State or Foreign Months Days 1**X**M 2□ F 40 7133 53 MARYLAND Yrs. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mexical Examinal must be notified at MD. N/ABALTIMORE 1XYes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4509 PALL MALL ROAD 21215 U.S. OF Funeral 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: BLACK by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) N/A UNKNOWN UNKNOWN UNEMPLOYED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) ALBERTA MITCHELL HORTON GREEN RICHARD LEE GREEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) BALTIMORE, MD. 21215 MRS. WANDALENE GREEN 4509 PALL MALL ROAD 20c. Location - City or Town, State BALTO. 20b. Place of Disposition (Name of cematary, cremetory or other place) 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING MEMORIAL PARK 9/12/97 BALTIMORE, MD. CO. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility **GWYNN** LEWIS T. GWYNN FUNERAL HOME 21215-6393 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest,

Approximate shock, or heart failure. List only one cause on each line. Interval Bety Onset and Death Immediate Cause (Final They the me Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical Due to (or as a consequence ot) Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Arrease þ 24e. Was an autopsy performed? 24b. Were eutopsy findings available prior to Completed completion of ceuse of death? menu 280 No 25. Was cese referred to medicel examiner? Be 26. Piace of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) ۲ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deet 28b Time of Medical Certification: 28c. Injury at Work? 28d. Describe how Injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as steted.

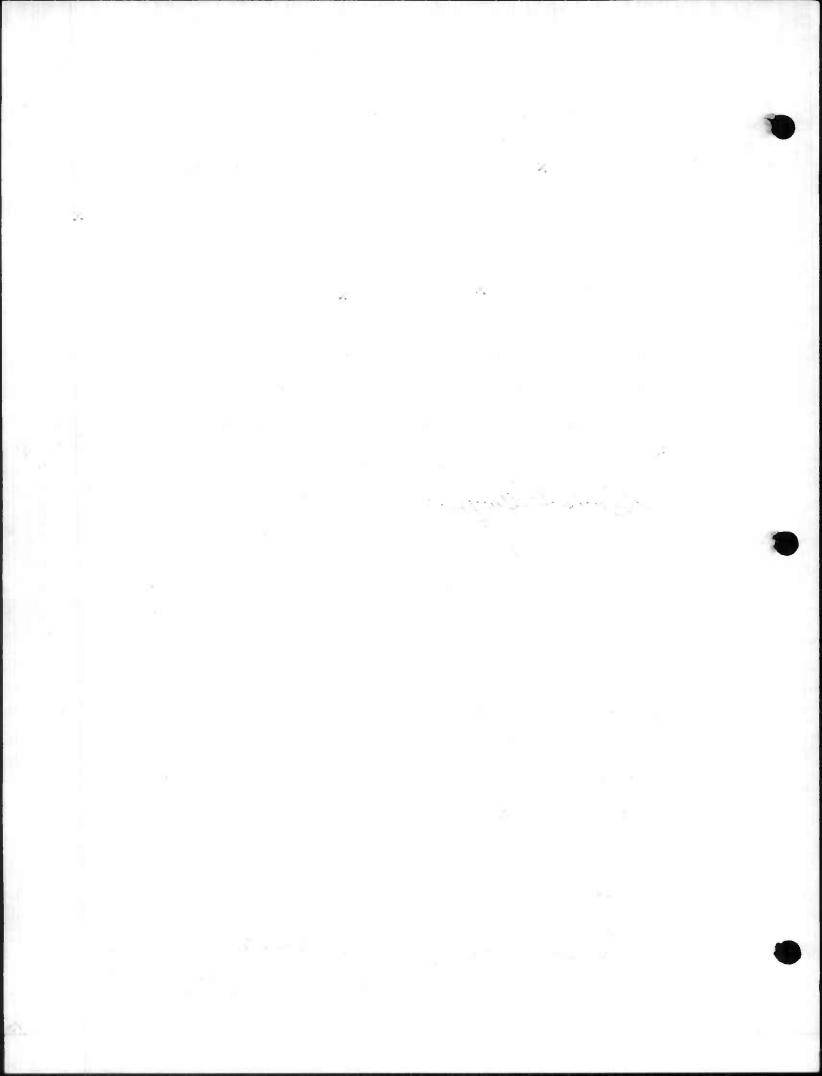
2 Medical Exeminer: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c Licansa number 29d. Date signed (Month, Dav. Year)

who completed ceuse of death (Item 23e) (Type, Print)

Honas

MB

State Registrar

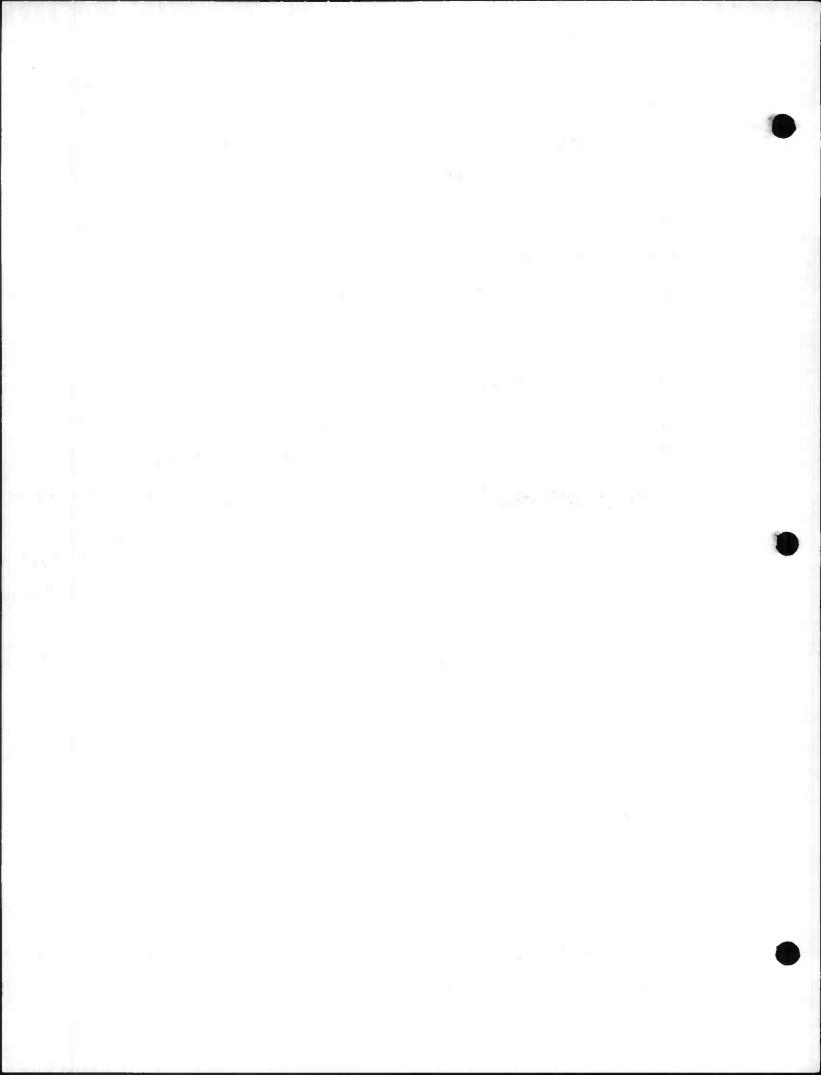


State of Maryland / Department of Health and Mental Hygiene 97

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| | | | | Ce | rtificate o | f Death | | Reg. No. | • | 401 |
|---|------------------|---|---|-------------------------------|---|---|--|---------------------------|-------------|--|
| Dhuoini | | Decedent's Name (First, Middle, Last | st) | | | | 2. Date of De Month | | Veer | 3. Time of Death |
| Physici /Medio | | JADINE | Α. | Ho | WARD | | SEPTEM | BER 7, | 1997 | 05:43AM |
| Examir | | 4a. Fecility Neme (If not institution, give | street and number) | | | 4b. City, Town, or | Location of Death | 4c. County | of Death | |
| | | THE JOHNS HOPKINS | | | William A Mar | BALTIMORE | _ | | | |
| Funeral Director | | 012 11 08 18 | PX 7. Age (III | n yrs. last birthday, Yrs. | Months Day | | 8. Date of Bird (Month, Da | th y, Year) 25 - 85 | 9. Birth | plece (State or Foreigntry) MD |
| show the | | Usuel Residence of Decedent 10e. State 10b. County | 10 | Oc. City, Town or L | | | | | | 10d. Inside City Limits |
| Ba-f | cto | mD | | Esse | У. | | | | | 1 ☐ Yes 2 ☐ No |
| s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. If marked other than "natural", or liems 23s or 28s-f show other traumetic event, its Medical Examinar man be notified a | Funeral Director | 10e. Street end Number 843 Northrux | lane | | 10f. Zip Code | 11220 | | 10g. Citizen of | What Cou | |
| r dea | Iner | 11. Maritei Status | 12. Was Decedent Eve Armed Forces? | r in U,S. 13. | Was Decedent o | f Hispenic Origin? (Suben, Mexican, Puerl | pecify Yes or No | - 14. Rac | ce - Americ | can Indian, |
| ours afte | by | 1) Never Mamied 2 Married 3 Widowed 4 Divorced | 1 Yes 2 No If Yes, Give Yeer or Dates: | | 1□Yes 2MN | | | Specif | | Black |
| 72 h | etec | 15. Decedent's Ed (Specify only highest gra | | 16a. Dece (Give | dent's Usuel Occ | upation se during most of wor red) | rking | 16b. Kind of B | usiness/In | dustry |
| 2 should be filed within and Mental Hyglene. a marked other than 's aumatic event, the Me | Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | | DO NOT use reti | | | Sch | 00/ | |
| othe othe | Be C | 17. Father's Neme (First, Middle, Last) | | | | | me (First, Middle, | Maiden Suman | ne) | |
| should be ind Mental i marked o umetic eve | To E | Detroy | Blackwe | 11 | | mai | ry G | reen | | |
| 2 sho | | 19a. Informant's Name/Reletionship (7 | | | | et and Number or Ru | | | | |
| f Health them 27 other tr | | Mary Black | | 843 20b. Placa of Dispo | | thrup L | | | | 21220 |
| 00- | | 20a. Method of Disposition 1 ■ Burlal 2 □ Cremetlon 3 □ | Removal from State | cemetery, cre | matory or other p | 4 1 | Date Ot 12 G2 | 20c. Location | - | , M.D |
| permit. Pag Department Important: It any Injury o | | 4 Donation 5 Other (Specify 21. Signature of Funeral Servica Licen | | Voshell | MEM 2. Name end Add | Garden | 9-12-97 | DUNC | XOLIC | 11100 |
| permit. Pages 1 at Department of Hea Important: If Item; any Injury or other once. | | - Unesso | SOA | | narch | F. H | EAST | 1101 | E. | North Ho |
| | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only | olications thet caused the | death. Do not en | ter the mode of d | ylng, such as cardiad | or respiratory er | rrest, | | Approximete interval Between |
| Physician /Madical | | Immediate Course (Figure | | | | | | | | Onset end Deeth |
| /Medical Examiner | | immediate Cause (Final disease or condition resulting In death) | a. Fungal | preum | unia | | | | | 7 days |
| | e | | | | - | | | | | , |
| od d | Examiner | Saguestially list appditions | | to (or es a consec | | | | | - | 15 worths |
| ficate be executed physician and is the buriel-trensit | | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury | _ | | | | | | | 2 months |
| ate be hysici | lical | Ceuse (Disease or injury that initiated events resulting in death) Lest | c. Due | DREKMA to (or as a consec | quence of): | | | | | 2 months |
| leath certificate be executed ettending physician and I for use as the bunel-trensit | Medical | | Derm | atemyosit | 14 | | | | 1 | 12 months |
| ath contend | | | | 7030 | | | | | | |
| requires that the death c seen signed by the ettend should be detached for us | Physician | Part ii. Other eignificant conditions co | | ot resulting in the u | nderlying cause | given in Pert I. | 23b. Dld 1 | A.e. | ntribute t | o the cause of death |
| es that tigned by | by Ph | Renal fail | ve | | | | 1 1 | Y 2000 | 3 Pro | bably 4 Unknow |
| Physician: The law requires the this certificate has been signeral director, page 2 should be to | | Renal fail | Ser . | | | | | an eutopsy | 24b. W | ere autopsy findings |
| aw requise been 2 shoul | Completed | Hepatic fa | ylure | | | | репо | rmed? | CO | eilable prior to impletion of cause death? |
| The law ate has b | mo | | | | | | 101 | res 200 No | 11 | ☐Yes 2☐No |
| ysician: The s certificate director, pag | Be | 25. Was case referred to medical examiner? | | | | 26. Plece of Dee | eth (Check only o | / ٧ | | |
| Physician: this certific ral director, | To | 1 ☐ Yes 2 No | Hospital: Inpatient | 2 ☐ ER/Outpatier | nt 3 DOA | Other: 4 Nursing H | lome 5 Resid | denca 6 □Oth | er (Specif | (y) |
| | Certification: | 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation | 28a. Date of Injury (Month, Day Ye | 28b. Time o injury | W | uryat lonk? □Yes 2□No | 28d. Describe h | now Injury occur | red | |
| = 5 de | ertific | 3 Sulcide 6 Could not be determined | 28e. Place of Injury - building, etc. (S | At home, farm, sti pecify) | reet, factory, offic | 9 | 28f. Location (5 City or Tox | | per or Rure | al Route Number, |
| Hospital or 24 hours effe Funeral Dir etaly filled in | edicai C | 29a. Certifier (Check only one) Certifying Phy Description 2 Medical Example 1 | vaician: To the best of my liner: On the besis of exa and manner steted | iminetion end/or in | n occurred et the vestigation, in my | time, date and pieca opinion, death occu | , and due to the oursed et the time, o | ceuse(s) end mo | enner as s | stated. the ceuse(s) |
| 600 | ≥ | 29b. Signature end title of certifier | | | | nse number | | 29d. Date signe | d (Month, | Day, Year) |
| | | | 1 | | | | | G1 | h | 7 1000 |
| | } | 30. Name end address of person who | ompleted cause of death | (ttern 23a) (Type | Print) | 0.0007 | | sepren | -000 | 7 1997 |
| | | Ellen M Nowhaus | Johns Howki | TIS HOSP | Piculema. | + LODN | wolfe Si | Beck | none | mn 21287 |
| Sta | te | 30. Name end address of person who of Wilen M Neurhaus 31. Date filed (Month, Day, Year) SEP 1 1 1997 | 32. Registrar's | Signature | | 1 | ,,,, | | 7 | |
| Registr | ar | 2EP I I 1997 | guia Durdson | -Aandelle | | | _ | | | |

DHMH 16 Rev 6/95



97-4915-510 JAMES HARRIS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

27488

Physician /Medical Examiner

Funeral Director

ASP

Funeral Director

þ

Completed

Be 2

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mental hygiena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Med cal Examinat must be notified at

Baltimore, Maryland 21215-0020

Physician /Medicai **Examiner**

Examiner ed by the attending physician and datached for use as the bunel-transit Division of Vital Records, P.O. Box 68760. Physician/Medicai signed by t by should Completed has Hospital or Attending Physician: 24 hours after death. Funeral Director: After this cartifice funeral director, Be Certification: To ely filled in by Medical

| | | | Cel | uncai | e oi | Dealli | | R | eg. No. | | |
|---|---------------------------|----------------------|-------------------|--------------------|----------------|----------------------|-----------------|--|----------------|--------------|--|
| 1. Decedant's Name (First, Middle TAMES Ea | a, Lasi) lward | Har | eis | | | | | 2. Dafa of Dea Month AUGUS | Dey | Year 1997 | 3. Time of Death 2:45A |
| 4a. Facility Name (If not institution | , give street and nur | nber) | | | | 4b. City, To | own, or L | ocation of Death | 4c. Count | y of Death | |
| JOHNS HOPKI | NS HOSPI | TAL | | | | BA | Hi | HORE | BAL | TIMO | RE |
| 5. Social Security Number 229-14-9506 | 6. Sex 1 M 2 ☐ F | 7. Age (In yrs. last | birthday) Yrs. | If Under Months | 1 Year Days | If Undar Hours | 24 Hrs. Min. | 8. Date of Birth (Month, Day 100. 18 | Year) 19 | | place (State or Foreigntry) |
| Usual Residence of Decedent | | | | | | | | | | | |
| 10a. State 10b. County | 1 | 10c. City, T | own or Loc | cation | , | | | | | 1 | IOd. Insida City Limits |
| Marylow | NB | 17 | BAL. | TIM | OVE | | | | | | .14Tes 2□No |
| 10e. Street and Number | | | | 10f. Zip | Code | | | 1 | 0g. Citizen of | What Cour | ntry? |
| 1821 E. Eac | ger Str | reet | | 0 | 210 | 05 | | | 05 | A | |
| 11. Marifal Status | 12. Was Dece | dant Evar in U,S. | 13. V | Vas Dece | denf of I | lispanic Or | igin? (Sp | ecity Yes or No- | | ce - Americ | |
| Never Married 2 ☐ Marri | | 2 No | | | | | | Rican, etc.) | Ble | ck, White, | efc. |
| 3 Widowed 4 Divorced | If Yes, Giv Year or Di | ates: WWI | 1 | ☐ Yes | 2No | Specify. | | | Speci | Blan | ck |
| 15. Decedent (Specify only highes | 's Education | 1. | Ba. Deced | ent's Usua | al Occup | oation during mos | at of word | ·laa | 16b. Kind of 8 | Businass/In | dustry |
| Elementary/Secondary (0-12) | Collage (1 | -40r 5+) | life. D | O NOT u | se retire | d) / | si ui wuir | (| Traves | Cor | tractung |
| 8H grade | Comago (| C | 1240 | LUC! | Son | Wor | Kor | | Co. | | |
| 17. Father's Name (First, Middle, I | Last) | | | | | 18. Moth | | e (First, Middle, I | | me) | |
| 19a. Informant's Name/Relations! | / / | | 9b. Mailin | | a// | / | er or Rui | BAIT | , | | 21237 |
| 20e. Method of Disposition 1 Burial 2 ☐ Cramation 4 ☐ Donetlon 5 ☐ Other (Sp. | | State Came | Son ; | Far E.S | ther pla | t. Co. | NEK | 9/12/97 | 20c. Location | 45 /1 | xills, NL |
| 21. Signature of Funaral Service I | Licensae | | 53 | 40,1 | 135 | STERS | Noa | ATHAN- RUAT | - Humi | FUN | eval Hume |
| 220 Part Frostha disease of | complications that a | august the death. F | | | | E. Me | | | | | |
| 23a. Part1. Enter the disease, or shock, or heart failure. List | only one cause on e | ach line. | o not ante | er the mod | ie or ayı | ng, such as | cardiac | or respiratory err | est, | 1 | Approximate Interval Between Onsef and Death |
| Immediate Cause (Final disease or condition resulting in death) | · An- | 1003 | in | | , C | AR | TOD | sau | DAY I | isers | g of |
| | | Due to (or as | a conseq | uerice or): | | | | | | 1 | |
| Sequentially list conditions, if eny, leading to Immediate | b | Due to (or as | e consequ | uence of): | | | | | | | - 1 |
| cause. Enter Underlying Cause (Diseasa or Injury that initiated events | С. | | | | | | | | | - [| |
| that initiated events resulting in death) Last | | Due to (or as | a consequ | ience of): | | | | | | | |
| | d | | | | | | | | | į | |
| | | | | | | | | | | 1 | |

Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I.

23b. Did tobacco usa contributa to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior fo completion of cause of death?

DUPSON 1 Yes 2 No

1 ☐ Yes 2 ☐ No

25. Wes case refarred to medical examiner? XXYes 2□ No 27. Manner of Death

5 Pending Investigation 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ fnpatient 2 ☐ ER/Outpatient 30 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how Injury occurred

28. Place of Deeth (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

0

State Registrar 2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

**Chief Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

**Chief Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and fifla of certifier

29c. License number O.C.M.E

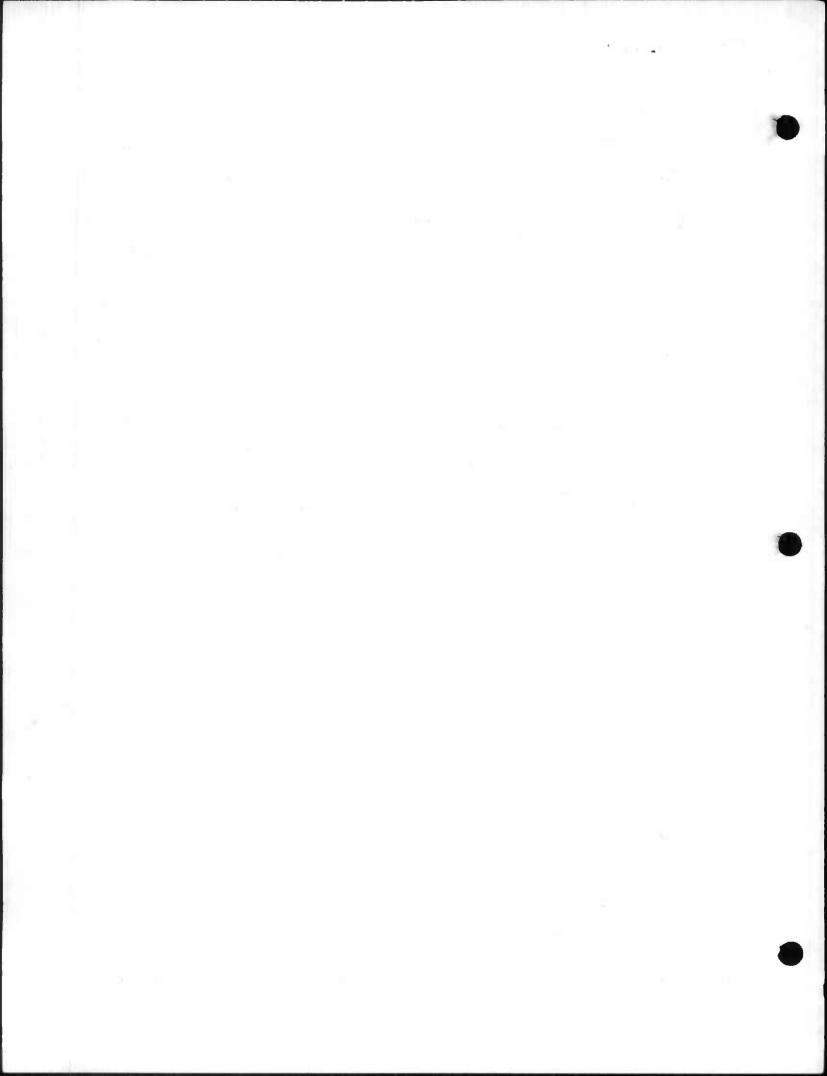
29d. Date signed (Month, Day, Year) AUGUST 29,1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 2120! MARypains

Hospitel:

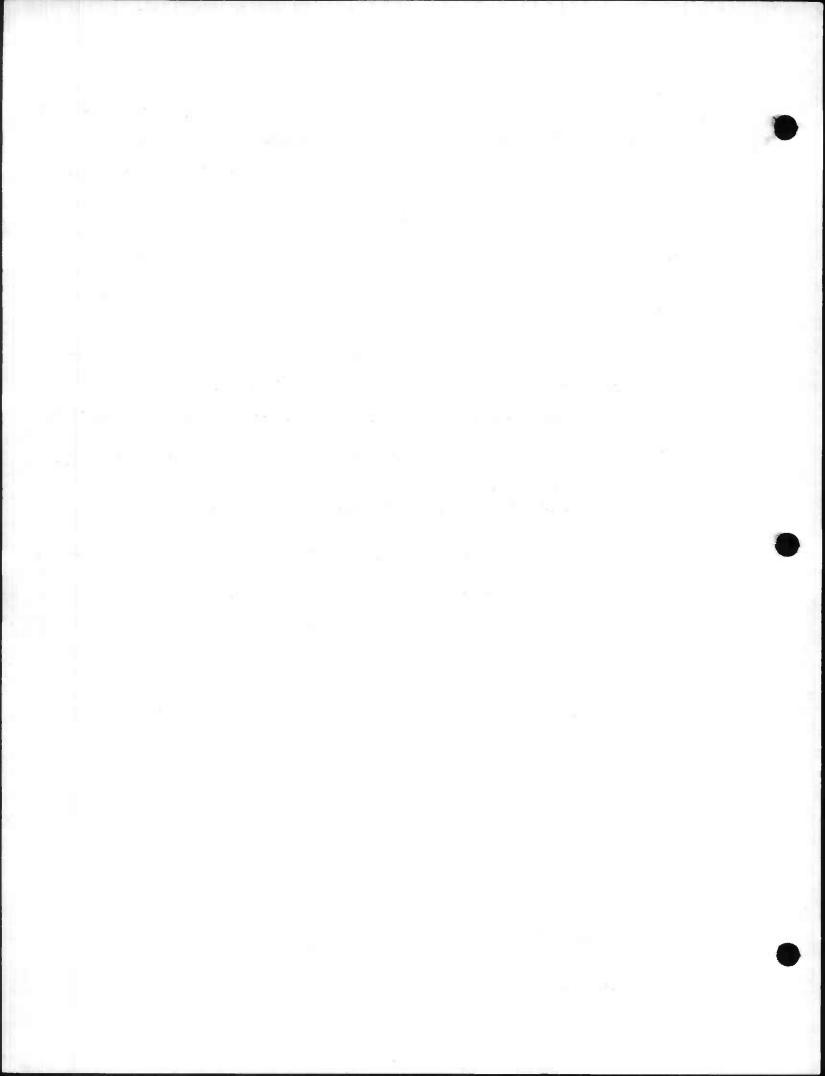
31. Date filed (Month, Day, Year)

32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene Q 7

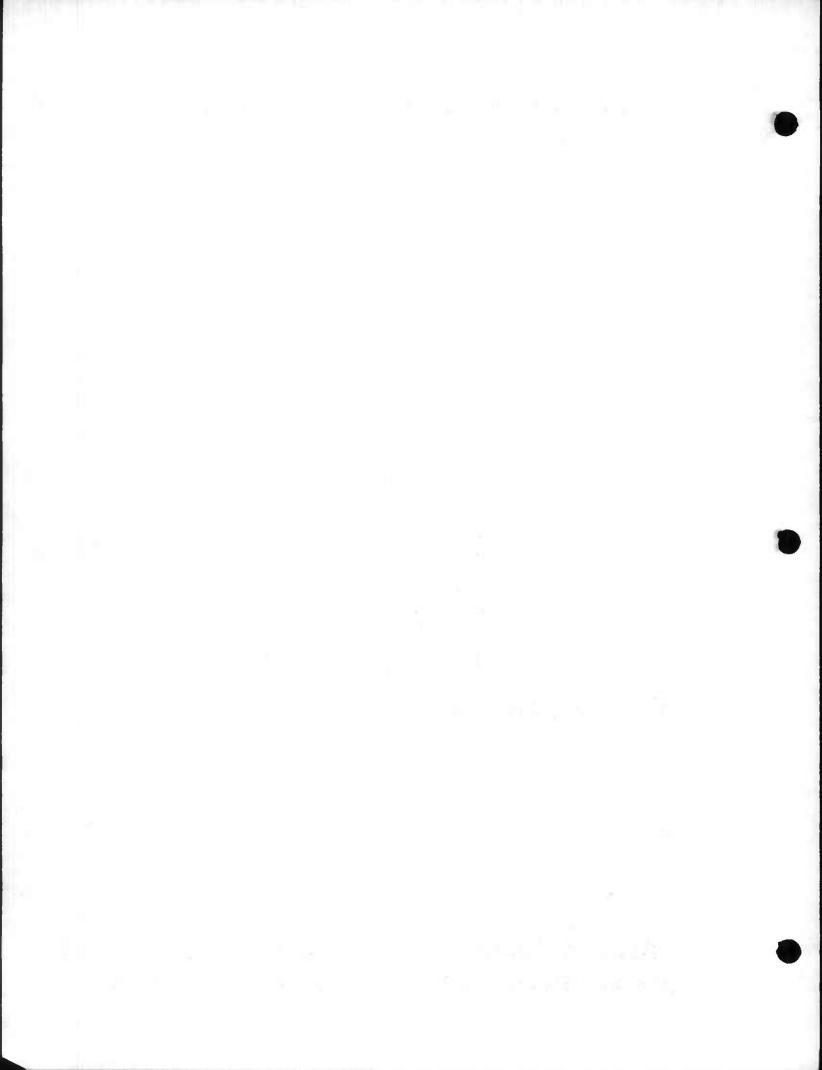
| | | | | | | | | Cert | ificate | e of | Death | | | Reg. No. | 21 | 6- | 1400 |
|------------|--|---------------|---|-----------------------|---|--|-----------------------------------|-------------------|--------------------------|--------------------|--|----------------------|---------------------------------------|-----------------------------|------------------------|-------------------------------------|------------------|
| | | | 1. Decedant'a Nama (First, Mic | ddla, Last |) | | | | | | | | 2. Date of D | eath | Vi | | Tima of Death |
| | Physic /Medi | | Ruth | Ca | therin | e Hef | ner | | | | | | Month Septemb | Day | 199 | | 120 AM |
| | Exami | | 4a. Fecility Neme (If not institu | | | | TICL | | | | 4b. City, To | wn, or L | ocation of Dee | | ounty of D | | |
| 7 | | | Deaton Med | ical | Cente | r | | | |] | Baltir | nore | | | N/A | | |
| | Funeral Director | | 5. Social Security Number 218–26–1589 | 6. Se | x IM 200 F | 7. Aga <i>(In y</i> | rs. last birtho | 1 | If Under Months | 1 Year Days | | 24 Hrs. Min. | 8. Data of Bi (Month, D NOV . 3 | rth ey, Year) 1905 | - | Birthplaca (Country) arviar | State or Foreign |
| н | | | Usual Rasidanca of Decedant | | | | | | | | | | 1.0.0 | 7 1300 | - 120 | 11111 | |
| | how | | 10a. Stata 10b. Cour | | | 10c. | City, Town o | | | | | | | | | 10d. In | sida City Limits |
| | Me Me | ctor | Maryland N | /A | | | Ba. | lti | more | | | | | | | 75 | Yas 2 No |
| | or 28 | Director | 10e. Street and Number | | | | | | 10f. Zip | Coda | | | | 10g. Citizar | of What | Country? | |
| | th w | | 611 S. Charles | St | reet | | | | | 2 | 1230 | | | Ţ | JSA | | |
| 21215-0020 | in 72 hours after death with the Maryland I "natural", or items 23a or 28a-f show fedical Examines must be notified at | by Funeral | 11. Marital Status 1 □ Nevar Married 2 □ M 3 □ Widowed 4 □ Divord | arriad | 12. Wes Dec Armed Fo 1 ☐ Yes If Yas, Gi Yeer or D | orcas? 2 ⊠No ve | U,S. | | | | Hispenic Ori ean, Mexicar Specify: | | pecify Yas or N Rican, atc.) | | Race - A Black, W | maricen Inc Thite, atc. White | |
| 0 | 72 ho | Pe | 15. Daced | ant's Edu | cation | | 16a. D | ecedar | nt's Usua | Occup | petion | | | 16b. Kind | of Busina | ss/Industry | |
| 218 | within 7 ene. than "n | Completed | (Specify only high Elamantary/Secondery (0-12 | - 1 | a complated) Collage (| 1-4or 5+) | - (6 | iva kir fa. DC | nd of wor NOT us | k dona a retire | during mos | t of worl | king | | | | |
| 21 | TO CO. by | E | A | , | Conage (| 1-401 34) | Pro | odu | ctio | n | | | | Par | er F | actor | ТУ |
| Maryland | D d la | To Be | 17. Fathar's Nama (First, Middle Theodore Sm | | | | | | | | 18. Moths | | a (First, Middle lie Agn | | mama) | | |
| | nd 2 shall be shall b | | 19e. Informant's Name/Relation John Joseph | | | on) | 19b. N 97(| Naiting | Addrass Libe | (Street | Road, | er or Ru | ral Route Numb ndallst | oer, City or To | own, Stete | e, Zip Code and 2 | 1133 |
| altimore, | o to | | 20a. Mathod of Disposition 1 Disposition 2 Cramatio 4 Donation 5 Other | | lamoval from | State | Place of D camatary, Oaklav | crama | tion (Name tory or of | her pla | , | 09 | Data /10/199 | | | or Town, Si | |
| Balti | permit. Peges Depertment of Important: If it any injury or once. | | 21. Signature of Funarel Sarvio | 11-1 | | /. | | D111 | raco | Ho | ess of Facili | mor | al Home | 21 | 1211 | | |
| Н | _ | | 23a. Part1. Enset the disaasa, shock, or least failure. L | or compl | ications that | Could the de | ath Do not | 36. | 31 F | all | s Road | l, B | altimor | e, Mai | cylar | pd | oximata |
| | Dharalalan | | shock, or yeart failure. L | ist only or | na causa on e | ech line. | satil. Do not | antan | tria mode | a or dyr | rig, sucri as | Cardiec | or raspitatory (| inest, | | intan | val Between |
| 1 | Physician /Medical Examiner | | Immadiata Ceuse (Final diseesa or condition rasulting in daath) | | a | CU IE | Myoca | orc | tial | (1) | Yeiro | Hay | svip | eolec | 1 | | miniles |
| | | - | in dading in | | | ^ | | | | | | | | | | | |
| Т | ed sit | i i | | | · + | there. | schoot | C | he | וזיים | h 0/1 | 160 | 100 | | | 10 | 4-5 |
| _ | end end I-trar | Examiner | Sequentially list conditions, if any, leading to immediate | | | Due to | (or as a cor | nsequa | nce of): | | fai | | | | | - 4 | |
| 68760, | the deeth certificate be executed by the ettending physician end sched for use as the bunal-transit | | Sequantially list conditions, if any, leading to immediate cause. Entar Underlying Causa (Disease or injury | 2 . | | myesi | | | Som L | - | fai | ·leve | 2 | | | 54. | 3 |
| 87 | phys the | Medical | thet initieted avants rasulting in death) Lest | | | | (or as a cor | | nca of): | |) | | | | | i | |
| × | ding p | /Me | | | d | Hypor | من مسا | U | | | | | | | | 104 | 3 |
| Bo | eeth ce ettendi for us | lan | | | | | | | | | | | | | | t | |
| 0 | by the de | Physician/ | Pert II. Other significant condi | tions con | tributing to de | eath but not r | asulting In th | na und | arlying ce | euse gi | ven in Pert I | | 23b. Did | tobacco us | s contrib | ute to the c | auss of death? |
| 9 | that the ded by | | Dioheles me | litu | 2 | | | | | | | | 1□ | Yss 2 | No 3 | Probably | 4 Unknown |
| Records, | requires | Completed by | | | | | | | | | | | 24a. Was | s an eutopsy ormed? | 24 | available | on of cause |
| Re | The law ate has t page 2 s | m d | | | | | | | | | | | | | | of death? | |
| B | | | 05 14(22 222 262 262 262 | | | | | | | | | | | Yes 2 1 | 40 | 1 ∐ Yas | 2 No |
| Vital | ysician: s certific director, | o Be | 25. Was cese rafarrad to mediaxaminar? | | fospitai: ا | | | | | Ott | har- | | th (Check only | | | | |
| of | 문 를 절 | | 1 Yes 2 No 27. Manper of Deeth | | 102 | | ER/Outpa 28b. Tim | | 3 DO | ^ | 40140 | irsing He | ome 5 Res | | - | (pecify | |
| n | Jing After fune | lo | 1 Netural 5 ☐ Pend | ding | (Mon | of Injury th, Dey Year) | Inju | | M | Bc. Inju Wo | rk? IYas 2□ | No | 200. Dascribe | now injury o | ccurred | | |
| Division | Attending r death. ector: After by the fune | ertification: | 3 Suicida 6 □ Coui | | ODe Diese | of talians At | hama Kim | - 4 | | | 1185 2 | 140 | OR Location | (Canada and A | humbar ar | Dural Bourt | to Atumbus |
| S | or Attended of the death Director: | T T | 4 ☐ Homicida dete | rmined | buildi | of Injury - At ing, atc. <i>(Spe</i> | noma, tarm cify) | , strea | t, tactory | , offica | | | 28f. Location City or To | wn, Steta) | rum <i>ber or</i> | Hurai Hout | a Number, |
| | ours illed | O | 000 Coasties 4 de | | | | | | | | | | | | | | |
| | Hospital or Attending 24 hours efter death. Funeral Director: After etely filled in by the funeral process. | edical | 29e. Certifier 1 Certify (Check only one) 2 Medic | ing Phys ai Examir | nar: On tha bi | best of my k asis of axami nar stated. | nowledge, d nation end/o | eath o | ccurred e stigation, | in my o | me, date en opinion, daa | d place, th occur | and dua to tha | cause(s) en data end pla | d manner ace, and d | r as steted. dua to the c | euse(s) |
| | | ĕ Z | 29b. Signature end title or certi | liar | and men | nar stated. | | | 290 | Licans | sa number | | - | 29d. Data a | toned (Mr | onth Day \ | (par) |
| | E SES | | | 1 | | | | | | | | 4 | | | | | / |
| | J.V | | | | | | | | | U 3 | , 0 7 7 | - 1 | | 4 | 181 | 97 | |
| | H | | 30. Nema and addraged person | | 0 4 | 660 1 | ullkon | | int) Are | | Balt | ima | re me |) 41 | 227 | | |
| | Sta Registi | | 31. Data files (Morth, Dev. Yea | 997 | 32.74 | legistrar's Sig | natura | nda A | 0. | | | | | | | | |



State of Maryland / Department of Health and Mental Hygiene 97

27490

| | | | | | Ce | rtificate o | f Death | | Reg. No. | | |
|-------------|--|----------------|---|--|-------------------------------|---|---|--|-----------------------------------|---------------------------|--|
| | Dis. | | 1. Decedent's Name (First, Middle, La | | | | | 2. Date of Dea | ath | Vaar | 3. Time of Death |
| | Physic /Medi | | FRADA | ICK W. J | UPITZ | - | | SELL | Day | /997 | 8:30 PM |
| | Exami | | 4a. Fecility Name (If not institution, giv | | | | 4b. City, Town, or L | ocation of Death | 4c. Count | y of Death | |
| ű | | | Howard County | General Hosp | pital | | Columb: | ia | Но | ward | |
| | Funeral Director | Г | 5. Sociel Security Number 6. S 220-07-2540 | ex 7. Age (In yrs. 76 | last birthday, Yrs. | Months Day | | 8. Date of Birt (Month, De DEC 27 | th y, Year) | 9. Birthpi Coun | place (State or Foreign htry) York |
| | D | | Usuel Residence of Decedent | | | | | DEO 27 | 1/20 | 116 14 | TOLK |
| | nylan show | | 10a. State 10b. County | 10c. City | y, Town or L | ocation | | | | 11 | 0d. Inside City Limits |
| | Ma Left | cto | MD Howar | d Ei | llico | tt City | 7 | | | | 1 ☐ Yes 2 ¼ No |
| | or 24 | Director | 10e. Street end Number | | | 10f. Zip Code | | | 10g. Citizen of | Whet Coun | itry? |
| | 23a | <u>a</u> | 9260 Maple Roc | k Drive | | 21 | 1042 | | USA | | |
| | er de | Funeral | 11. Maritel Status | 12. Wes Decedent Ever in U. Agmed Forces? | S. 13. | Was Decedent of | f Hispanic Orlgin? (Spuben, Mexican, Puert | pecify Yes or No- | - 14. Re | ce - America | |
| 21215-0020 | iges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mantai Hygiene. If items 23s or 28s-f show or other traumatic event, the Modical Experient must be inclined at | þ | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | tX Yes 2 □ No If Yes, Give WW Year or Dates: | | 1□ Yes X□ N | | , | | ⁄y:Whi≀t | |
| 5-0 | 72 h | Completed | 15. Decedent's Ed (Specify only highest gra | fucation | 16e. Dece | dent's Usuel Occ | upation e during most of work | kina | 16b. Kind of 8 | Jusiness/Inc | dustry |
| 21 | ithin a | g | Elementery/Secondary (0-12) | College (1-4or 5+) | life. | DO NOT use reti | red) | Na in in | Vendi | ng Ma | achine |
| | ygien ygien ft. | S | 9 | | Rou | te Sale | | | Sa | les | |
| Maryland | be filed tal Hygi d other | Be | 17. Father's Name (First, Middle, Last, | | | | 18. Mother's Nem | | | | |
| yla | should t nd Mant marked | ို | Richard J | upitz | | | l l | Margare | ete Eb | erlir | ng |
| Jar | and and is m | | 19a. Informant's Neme/Reletionship (| Type, Print) | 19b. Maili | ing Address (Stre | et and Number or Ru | ral Route Numbe | er, Clty or Town | , State, Zip | Code) |
| | 1 and Health em 27 | | Dorothy A. Jupitz | /Wife | 9260 | Maple R | ock Dr. | Ellicott | City. | MD210 | 742 |
| Ore | of H of H | | 20a. Method of Disposition 1 ☐ Buriel 2 🐧 Cremation 3 ☐ | Removel from State | tece of Dispo emetery, cre | osition ?Name of m <i>atory or other p</i> | (ace) | Date | 20c. Location | - City or To | wn, State |
| altimore, | Pages ment of ant: if its ury or o | | 4 Donation 5 Other (Specif | Me | tro C | rematory | , Inc. 09/ | /11/97 | Baltin | nore, | MD |
| alt | permit. Pages 1 an Department of Heal Important: if Item 2 any injury or other once. | | 21. Signature of Funeral Service Licer | 1500 | 2 | 2. Name end Add | ress of Facility Society | of Monre | land T | | |
| 0 | 80559 | | De aunia | Mysomala | 2 | 299 Frede | erick Rd. | Baltimo: | re MD | 21228 | |
| | | -7 | 23a. Part1. Enter the disease, or com shock, or heert failure. List only | plications that caused the death | | | | | | 21220 | Approximete |
| | Physician | | briotic, or ricore tangets. Clar only | one cause on each mie. | | | | | | 1 | Onset and Death |
| | /Medicai | | Immediate Ceuse (Final disease or condition | Sepri | Γ | | | | | | 10 Down |
| | Examiner | | resulting in deeth) | Due to (o | r es e conse | quence ot): | | | | | - Sugn |
| | D # | ner | _ | · PMOUN | ushia | | | | | | V |
| | and trans | Examiner | Sequentially list conditions, if any, leading to Immediate | U. | as arconse | 3 | | | | | |
| Ó, | ian a | | if any, leading to Immediate cause. Enter UnderlyIng Cause (Disease or Injury | Kerns | dai | luro | | | | | |
| 68760, | ate b hysic the b | Ilca | that initieted events resulting in death) Last | Que to (or | as e consec | | . 1 | | | 1 | |
| × | eath certificate be axecuted attending physician and for use as the burial-transit | Medicai | | . Chron | (Lun | nahoculi | - Cente | ruia | | 1 | |
| Bo | ath o | an | | | 0 | 0 0 | | | | | |
| 0 | requires that the death een signed by the atter hould be detached for u | Physician | Part II. Other algnificant conditions of | ontributing to death but not resu | Iting in the u | ınderlying cause (| given in Pert t. | 23b. Did t | lobacco use co | ontributa to | the cause of death? |
| ٥. | d by detac | | 1); afely Ma | Ultus At | 1100 | tilni | Dutin | 10 | Yes 2 No | 3 Prob | bably 4 Unknow |
| S, | S 5 5 | by | 2,200 | , , , , , | · · | 0 1000 | | | | | |
| Records, | v require been si shouid | Completed | | | | | | 24a. Was perfo | an autopsy rmed? | ava | ere autopsy findings allable prior to |
| ec | aw 1s b | npie | — | | | | | | | of c | mpletion of cause death? |
| | The ate t | S | | | | | | 1 🗆 Y | res 20 No | 1 🗆 | Yes 2□ No |
| Viital | Physician: The i this certificate har ral director, page | Be | 25. Was case referred to medical examiner? | | | | 26. Plece of Dee | th (Check only o | ne) | | |
| | Physic this co | 2 | 1 ☐ Yes 2 2 No | Hospitel: 15 Inpatient 2 | ER/Outpatie | nt 3 DOA | Other: 4 ☐ Nursing H | ome 5 Resid | dence 6 Dot | ner (Specify | v) |
| u | ng Ph fter th ineral | i. | 27. Menner of Death 1 ☑ Natural 5 ☐ Pending | 28e. Dete of Injury (Month, Day Year) | 28b. Time o tnjury | at 28c. Inj | ury at ork? | 28d. Describe h | now Injury occu | rred | |
| sio | Attending is death. ector: After by the funer | cati | 2 Accident Investigation | | | M 1 | ☐ Yes 2 ☐ No | | | | |
| Division of | or Att after d Direct I in by | Certification: | 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homlcide determined | 28e. Place of Injury - At he building, etc. (Specify | me, farm, st | reet, factory, offic | 0 | 28f. Location (5 City or Tox | | ber or Rura | I Route Number, |
| | after after Direction | | | | | | | | | | |
| | | edical | 29a. Certifier (Check only one) Certifying Ph 2 | ysician: To the best of my know stner: On the basis of examinat and manner steted. | wledge, deet ion and/or In | h occurred at the vestigation, in my | time, date and place, opinion, death occur | , end due to the or rred at the time, o | cause(s) and m date and place, | anner as st and due to | the cause(s) |
| | Fig. | Me | 29b. Signature and title of cartifier | | | 29c. Lice | nse number | | 29d. Dete signe | ed (Month. I | Day, Year) |
| | P B B | | $\rightarrow \Lambda \Lambda_{-} \Omega(Y)$ | 1,000 | ٦ (| (1 | 20011 | | - | 1 10 | 202 |
| | | | 20 Name and State Co | 7 Cellus V | 20, | 17 | 5/211 | | 61. | 1,1 | 17/ |
| | | | 30. Name end eddress of person who | completed cause of deeth (Item | 23e) (Type, | KNIAI / | N. DRIV. | 0 00 | LUMBIA. | NIA | 21005 |
| | Sta | 10 | 31. Date filed (Month, Day, Year) | 32. Registrar's Signal | ure | 1-100- | M. Mar | 7 60 | Caldalin | INO. | 4177 |
| | Registi | | SEP 1 1 1997 | July Davidson | | e. | | | | | |
| | | | | (1) | | | | | | | |

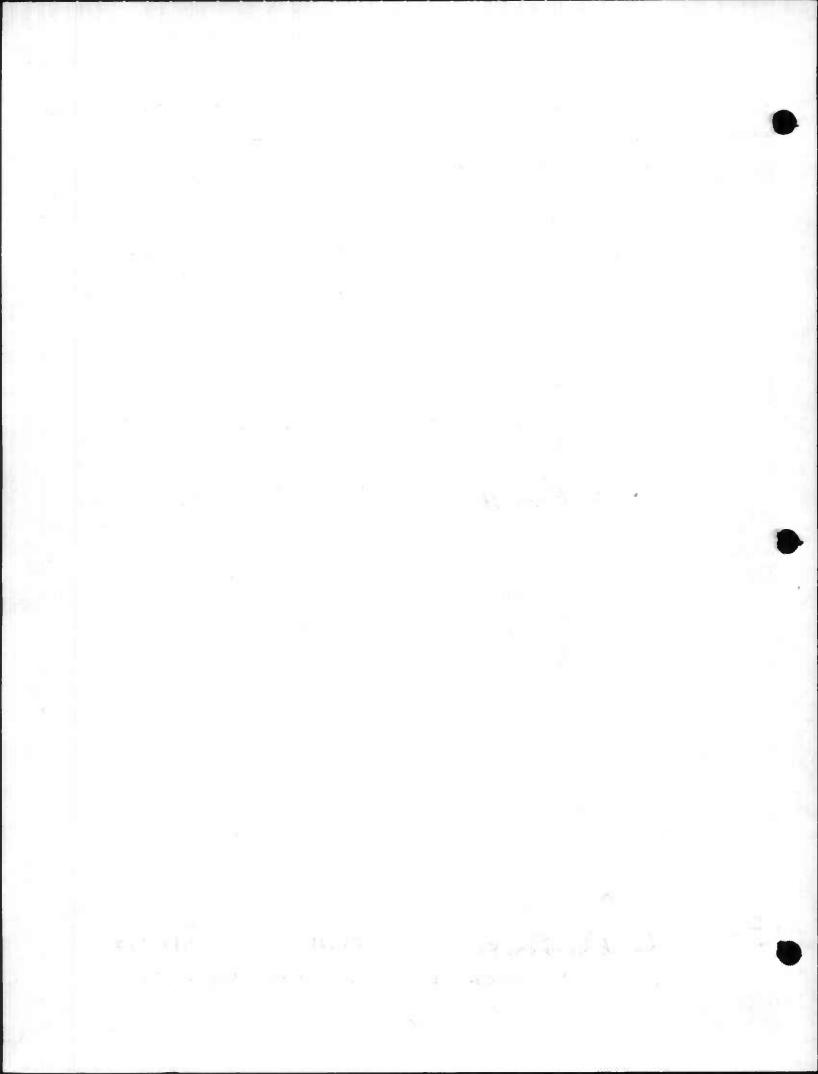


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 97

27491

| | | | | | | Ce | rtificate | of | Death | | | Reg. | No. | | |
|------------|--|---------------------|---|--|-----------------------------------|-----------------------------|--|---------------|---|----------------------------------|------------------------------------|-----------------|-----------------------------|--------------------------------|--|
| | Dhuais | ian | 1. Decedent's Name (First, Middle, La | , | | | | | | | Date of De Month | ath | | Vace | 3. Time of Deeth |
| | Physic /Medi | | | Johnso | | | | | | Se | ept. | 9 | Day 199 | Year | 10:45 am |
| 7 | Exami | | 4a. Fecility Name (If not institution, given 953 Martin Rd. | re street and numb | er) | | | | | own, or Locati | on of Deet | | 4c. County Balti | | |
| | Funeral Director | | 5. Social Security Number 6. S 210-16-8048 Usuai Residence of Decadent | Sex 7. | Age (In yrs. le 76 | st birthday) Yrs. | If Under 1 Months | Year Days | If Under Hours | 24 Hrs. 8. Min. | Date of Bir (Month, De t. 22 | | | 9. Birthi Cou | place (State or Foreign ntry) land |
| | wor. | | 10a. State 10b. County | | 10c. City, | Town or Lo | ocation | | | | | | | 1 | 10d. inside City Limits |
| | n the Marylen r 28a-f show | io | Maryland Baltimor | e | | | | E | ssex | | | | | | 1 ☐ Yes 2 No |
| | or 28 | Dire | 10e. Street end Number | | | | 10f. Zip C | ode | | | | 10g. | Citizen of | What Cou | ntry? |
| | 23a | rai | 953 Martin Rd. | | | | | 212 | 21 | | | U | .S.A. | | |
| 21215-0020 | 72 hours efter death with the Maryland natural; or items 23s or 28s-f show pred Examiner must be notified at | by Funeral Director | 11. Maritai Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced | 12. Was Decede Armed Force 1 Types 2 if Yes, Give Year or Dete | s? | | Was Decede If Yes, specif 1□ Yes 2 | | lispanic Ori en, Mexicar Specify: | igin? (Specify n, Puerto Rica | Yes or No in, etc.) | | Bla | ce - Americk, White, y: Whi | |
| 5-0 | should be filed within 72 hours nd Mental Hygiene. Tranked other than "natural", matic event, the Medical Exa | Completed | 15. Decadent's Ed (Specify only highest gre | ducation | | 16a. Deced | dent's Usual | Occup | ation | at of working | | 16b | . Kind of B | usiness/în | dustry |
| 121 | s 1 end 2 should be filed within 72 h if Health end Mental Hygiene. Item 27 Is marked other than "natu other traumatic event, the Medical | mpi | Elementary/Secondary (0-12) | Coilege (1-4d | or 5+) | | | retired | d) | st of working | | | | | |
| | filed v Hygie offher t | ပိ | 5 17. Father's Name (First, Middle, Last) | | | Plum | mer | | 10 Math | ada Nama /Fi | | | erosp | | |
| Maryland | buld be filed with Mental Hygiene. Arked other than attic event, the Manager | Be C | George Washington | | | | | | | er's Neme (Fi | | Meid | oen Sumen | ne) | |
| aryl | 2 should lend should lis marked | 2 | 19a. Informant's Name/Relationship (| | | 19h. Mailir | na Address (| Street | | Wolfe er or Rurai Ro | | er Ci | ty or Town | State 7ir | Code) |
| - | end 2 saith er n 27 is | | Lucinda Ann Water | | ghter) | | | | | Balti | | | | | (0000) |
| altimore, | | 34 | 20a. Method of Disposition 1 XBuriai 2 Cremation 3 4 Donation 5 Other (Specification) | Removal from Sta | 20b. Pia | ce of Dispo | sition (Neme | of er plea | ce) | D | ate | 20c | . Location - | City or To | own, State Co. Md. |
| Balti | permit. Page Department of Important: If any Injury or | | 21. Signetule of Auneral Service Ligar | 900 / | 0 | 22 | . Neme and | Addre | ss of Fecili | ty | D | | | | |
| | | | 23a. ya 11. Enter the disease, or com shock, or heart failure. List only | pilcetions that caus | sed the death. | Do not ent | 07 Old | Ea of dvin | asteri | n Avent | ie E | SS6 | ex, Mo | d21 | Approximate |
| d | Physician | П | shock, or heart failure. List only | one cause on each | ı iine. | | | | | | ,, | | | | Interval Between Onset end Death |
| ı | /Medical | Ш | Immediete Cause (Finai disease or condition | m 11. | 1. 5 | 1 1. | | | | | | | | i | 10 |
| п | Examiner | | resulting in deeth) | a. Mult. | Due to (or e | s a conseq | uence of): | | | | | | | | 10 mos |
| | D E | iner | | b. Hear | + 120 | onb. | | | | | | | | | 2-3 455 |
| | and trans | Examiner | Sequentieily list conditions, | 0. | Due to (or e | | | | | | | | | | - 3 3 3 |
| 60, | be ex clan burial | | Sequenticily list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | c. AThero | selerot | hie t | tear t | 0 | liseau | re | | | | - | 710 45 |
| x 68760, | leath certificate be executed attending physician and for use as the bunal-transit | Medical | thet initiated events resulting in death) Last | d. | Due to (or e | | uenca of): | | | | | | | 1 | |
| Вох | atten for u | Physician/ | | | | | | | | | | | | | |
| 0 | requires that the death een signed by the atter hould be detached for | ıysi | Pert ff. Other significant conditions of | ontributing to death | but not resulti | ng in the ur | nderlying cau | se giv | en in Pert i | | | | | | o the cause of death? |
| 9 | es that igned b | | | | | | | | | | 10 | Yss | 2 No | 3 Pro | bably 4 Unknown |
| Records, | n sign | d by | | | | | | | | - | 24a. Was | en eu | itopsv | 24b. W | ere autopsy findings |
| 00 | - LD (1) | lete | | - 32 | | | | | | | perfo | rmed | ? . | co | ailable prior to impletion of cause death? |
| Re | The law ate has page 2 | Completed | | | | | | | | | 40 | 1 | o Mate | | |
| Vital | Ifficat | 0 | 25. Wes case referred to medical | | | | | | ne Diese | of Dooth (Ct | 1 🗆 \ | | 2 No | 11 | Yes 25 No |
| > | Physician: this certific | To B | examiner? 1 ☐ Yes 2 No | Hospitei: 1 ☐ inpa | tient 2 🗆 EE | ?/Outpatien | t 3 DOA | Oth | 06: | of Deeth (Clursing Home | - 1 | | 8 DO# | or /Casail | 5-1 |
| 10 | Phy er this | | 27. Manner of Deeth | 28a. Date of in | njury 2 | 8b. Time of | | . Injun | | | | | 8 Oth | | V) |
| ior | Attending Ph r death. ector: Affer th by the funeral | atio | 1 Neturai 5 ☐ Pending 2 ☐ Accident investigation | | Dey Yeer) | injury | м | | k? Yes 2⊡ | No | | | | | |
| Division | or Attender after death | Certification: | 3 Suicide 6 Could not be determined | 288. Place of I | njury - At home etc. (Specify) | e, farm, stre | et, factory, o | office | | | Location (S City or Tow | | | er or Rure | el Route Number, |
| 1 | n E Furber | edical | 29a. Certifier (Check only one) Certifying Phy 2 Medical Example (Check only one) | rsician: To the besing | of examination | edge, deeth n end/or inv | occurred at estigetion, in | the tin | ne, dete en pinion, dea | d placa, and o | due to the o | cause date a | e(s) end ms and place, a | and due to | lated. the cause(s) |
| 1 | H | X | 29b. Signeture end fitie of certifier Bellah men | 2000 | 0 | | | | number 118 | | | | Date signed | | Dey, Year) |
| 1 | | | 30. Name and address of person who co Babala Imanal, D | completed cause of | death (Item 2: | 3a) (Type, 1 | Print) | · . | BU | to, 1 | 4D | 2 | 1237 | | |
| | Sta | | 31. Date filed (Month, Day, Year) SEP 1 1 1997 | 32. Regis | strar's Signatur | | | | | | | | | | |
| | Registr | ar | or 1 1 199/ | Juna Laur | dson-Ran | delle | | | | 10 | | | | | |

DHMH 16 Rev 6/95 JotuA



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Vasi CUANDAY JORDON SEPTEMBER 9 1997 12; 45 AW 4e. Fecility Neme (If not institution, give street end numbar) 4b. City, Town, or Location of Death 4c. County of Death BAYVIEW HOSPITAL BALTO
If Undar 1 Yaar | If Undar 24 Hrs. | 8, [
Months Deys Hours Min. 7. Aga (In yrs. last birthdey) Birthplace (Steta or Foreign Country) 1□ M 3€ F **Vrs** 3,8 MAR 14, 1959 10c. City, Town or Location 10d. inside City Limits Yes 2 No N/A BALTO 10f. Zip Code 10g. Citizen of Whet Country? U.S.A CT APT 5 21217

13. Was Decedent of Hispanic Origin? (Specify Yas or Noif Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forces? Race - Amaricen indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Yes 2 ☐ No

Specify:

DELI

1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Dete signed (Month, Day, Year)

26. Place of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 ☐ Yes 2 ☐ No

18. Mother's Name (First, Middle, Meiden Sumema)

ANN JORDAN

19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code)

16b. Kind of Business/Industry

BLACJ

Funeral Director

Physician

/Medicai

Examiner

5. Sociel Sacurity Number

10a, Stete

Director

Funeral

à

Completed

Be

P

220-68-0934

Usuei Rasidence of Decedent

MD

1606 VINCENT

1 Navar Married 2 ☐ Married

3 Widowed 4 Divorced

Elemantery/Secondary (0-12) 1 1 th

17. Father's Neme (First, Middle, Last)

TONY DELEAVER

Dulistance alrese

5 Pending investigation

6 Could not be datermined

een

Hospital:

30. Name and address of person who completed one of deeth (Item 23a) (Type, Print)

28a. Dete of Injury (Month, Dey Year)

1 ☐ Inpatiant 2 DER/Outpatient

CWI

avidson-Randale

Ti.

32. Registrar's Signature

28b. Tima of

28e. Place of Injury - At homa, farm, street, fectory, office building, etc. (Specify)

25. Was cese referred to medical examiner?
1 ☐ Yes 2 ☐ No

29b. Signatura and title of certifiar

31. Date filed (Month, Day, Year) SEP 1 1 1997

27. Manner of Death

1 Naturel

2 Accident

3 Suicida

29a. Certifier

4 Homicide

(Check only one)

19a. Informant's Name/Relationship (Type, Print)

10e. Street and Number

11. Merital Stetus

10b. County

15. Decedent's Education (Specify only highest grada completed)

College (1-4or 5+)

N/A

with the Merylend 28a-f show 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified as permit. Peges 1 and 2 should be filed within 72 hours after death w Department of Heelth and Mental Hyglene.

Important: If flem 27 is marked other than "natural". or Homely injury or other traumatic avaination.

Physician /Medical **Examiner**

attending physician and for use es the buriel-transit signed by the a d be detached f s certificate has b director, page 2 s

Hospital or Attending Physician: The law requires that the deeth certificate be executed Division of Vital Records, P.O. Box 68760, After this death. after deat Director: filled in by 24 hours a To the Hosp within 24 ho To the Fune completely fi

Completed

Be

Certification: To

Medical

| | KIMBERLI JURDAN/DAUGH | TTER 82 | 8 N. CHAPEL S' | T BALTO, MD 2120 | 5 |
|-----------------------|---|-----------------------------------|--|--------------------------------|---|
| | 20a. Method of Disposition 1 Burial 2 Cramation 3 Ramoval from 5 4 Donation 5 Other (Specify) | State | Disposition (Neme of y, crametory or other place) ION CEM | | ity or Town, Steta |
| | 21. Signature of Funeral Service Licensee Antica Be | tte | 22. Name end Addrass of Facilities 1129 N. CARO | BETTS FUNERAL H | OME D 21213 |
| | 23a. Part 1. Enter the disease, or complications that conshock, or haart failure. List only one cause on elimmediate Cause (Final | ach line. | , | cardiac or respiratory arrest, | Approximate Interval Between Onaet end Death |
| liner | I . | Due to (or as e c dosis; Cavi, | | AFB (0 x3, 1906) | years |
| al Examiner | Sequentially list conditions, if any, leading to immediate ceuse. Enter Undarfying Cause (Diaease or Injury that initiated events | Due to (or as a c | onsequence of): | | |
| an/Medical | rasulting in daath) Last | Dua to (or as a co | onsequence of): | | 1 |
| pleted by Physician/M | Pert tt. Other significant conditions contributing to de Pseudamenas preuma | _ | the undarlying cause given in Part i | | ribute to the cause of dea |
| pleted t | transamenits with Co | agulopath | 4 | 24e. Was an autopsy performed? | 24b. Were autopsy finding available prior to completion of cause of death? |

3 DOA

346C

28c. Injury at Work?

15 Certifying Physician: To the best of my knowledga, death occurred at the time, date end place, and due to the cause(s) end mennar as stated.
2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

1 Yes

2 No

16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired)

CASHIER

State

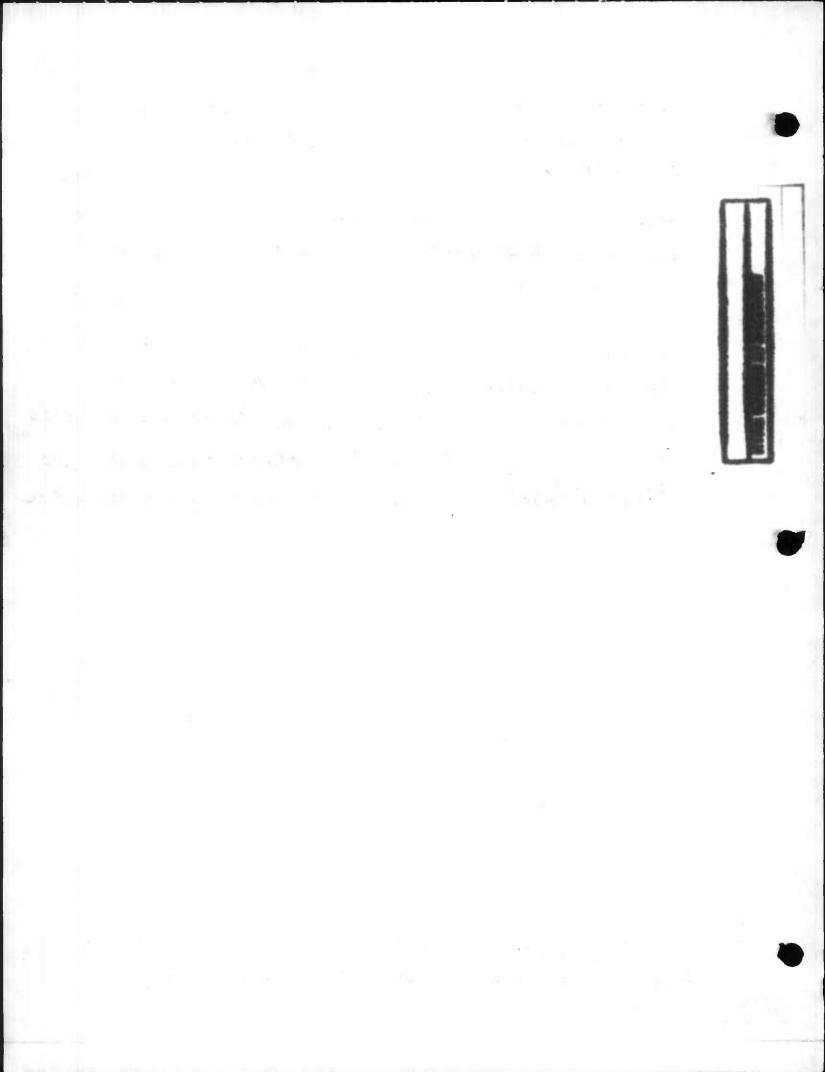
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0.7

| | | | d Daniel de Marie | (F) A A | | | Cer | tificate of | Death | r | Reg. No. | 71 | 2/49 | 3 |
|--------------------------------|--|------------------|---|---|--|--|------------------------------|---|---|--------------------------------------|----------------------------------|-----------------------------------|---|------|
| - 8 | Physici | an | Joseph | e (First, Middle, Les C John | * | | | | | 2. Dete of Dec Month | Day | Year | 3. Time of Deeth | |
| | /Media | | 4e. Facility Neme (/ | | | var) | | | 4b. City, Town, or Lo | Sep | 40 Caust | 1897 | 3:50 P | |
| | Examir | ner | Church | n Hosp | 1 . | er, | | | Baltimo | re | | or Death | | |
| 1 | Funeral Director | | 5. Sociel Security N 217-26 | - 7287 1 | X M 2□ F 7. | Age (In yrs. 72 | last birthday) Yrs. | Months Deys | | 8. Dete of Birt (Month, De 7-5 | h v, Year) - 25 | 9. Birthp Cour | elece (State or Fore | ign |
| | 7 | | Usuel Residence of 10a. Stete | Decedent 10b. County | | 10c. City | y, Town or Loc | cation | | | | | 0d. Inside City Limi | lt o |
| | Ra-I sho otified a | ector | MD | | | | | Imore | , | | | | 1 Yes 2□N | |
| -> | eath with the right of 2 | Funeral Director | 10e. Street and Nur 1300 | E. Lanu | ale St | Apt | 224 | 10f. Zip Code | 21213 | | 10g. Citizen of | | try? | |
| 020 | or nem | by | 11. Meritei Status 1 ☐ Nevar Marri 3 ☐ Widowed | | 12. Wes Dacede Armed Force 1 X Yes 2 If Yes, Give Year or Data | ss? □ No | | Ves Decedent of Yes, specify Cul | Hispanic Origin? (Speban, Mexican, Puerto Specify: | ecify Yes or No- Rican, etc.) | 14. Rac Bla Specif | ce - Americ ck, White, y: B | | |
| Baltimore, Maryland 21215-0020 | iem 27 is marked other train natural; other traumetic event, the Medical Ex | Completed | (Spec | 15. Decedent's Edu ify only highest gred ndery (0-12) | cation le completed) Coilega (1-4d | or 5+) | (Give I life. D | | e during most of work | | 16b. Kind of B | usiness/ind | lustry | |
| 121 | net the | | 7th gra | | | | | Truck | Drives | | | | | |
| vlanc | is manked other train traumatic event, the M | To Be | 17. Fether's Name (| | Baker | | | | 18. Mother's Name | | John John | | J | |
| Mar | 27 is mer | | - | Tohnsor | | | 19b. Mailin | Colonia | at end Number or Rurs | el Route Number Chesa | r. City or Town, peake, | State, Zip | 2332 | 5 |
| ore. | | | 20e. Method of Disp | osition Cremetion 3 F | | | leca of Dispos | ition (Neme of etory or other pla | | Dete | 20c. Location - | - | | |
| i i | E g S | | | 5 Other (Specify) | | Gi | arriso | in fore | st Vet-Can | 9-12-97 | awings | s m | ills , MD | |
| Bal | permit. Depertrainmonts any inju | | 21. Signature of Fur | neral Service Licens | 100 | | | Name end Addr | | - | 1111 + | - 11. | rth Av | 0 |
| | 4-15-1 | | 23a. Pert1. Entar th | e disaasa, or compl | ications that caus | sed tha death | | r the mode of dy | F, H, EA | | | 740 | Approximete | _ |
| • | Physician /Medical Examiner | | Immediate Cause (I disease or condition resulting in death) | Final | ACU | | Zenal | Failu | re | | | | Interval Between Onset and Deeth | |
| | | je. | rooting in dooring | | ν. (| | Prosh | | 1 | | | 1 | , | |
| | icete be executed physician end s the buriel-transit | Examine | Sequentielly list con | ditions. | . / Tex | | es e consequ | | ancen | | | i | 195 | |
| 90, | Sian e | | Sequentially list con if any, leading to Im cause. Enter Under Ceuse (Disease or I | mediete lying | | | | | | | | | 0 | |
| 68760, | physic the b | Medical | thet initieted events resulting in deeth) L | | , | Due to (or | es a consequ | enca of): | | | | | | |
| Box | nding ph use es t | | | | J | | | | | | | | | |
| Ø. | death ce | sicia | Part II. Other signific | cant conditions cor | tributing to death | but not resu | iting in the un- | deriving causa o | iven in Pert I. | 23b. Did to | obacco use co | ptribute to | the cause of deat | h? |
| , P.O. | es that the death ce igned by the attendi be detached for use | by Physician/ | Emphyse | | aturia, | | | | | | | | eably 4 Unkno | |
| Division of Vital Records, | | Completed | . 0 | | | | | 0 | | 24a. Was a perfor | an eutopsy med? | ava | re eutopsy findings allable prior to appletion of cause death? | 1 |
| A. | The law ate has page 2 | Eo | | | | | | | | 1 U Y | es 20 No | 10 | Yes 20 No | |
| /ita | ysician: The | Be | 25. Wes case referre | | | / | | | 28. Piece of Deeth | (Check only or | ne) | | | |
| of | Physic this c | 2 | 1 Yes 2 | lo F | Idspital: 1 Inpa | | ER/Outpatient | 3LI DON | her: 4 Nursing Hor | | | |) | |
| ion | death. ctor: After y the funer | ertification: | 27. Menner of Deeth 1 ✓ Netural 2 ☐ Accident | 5 Pending investigation | 28e. Dete of Ir (Month, L | Dey Year) | 28b. Time of Injury | 28c. Inju Wo M 1 | ry et vrk?] Yes 2 □ No | 28d. Describe h | ow injury occur | red | | |
| Divis | i ga g | Certific | 3 Suicide 4 Homicide | 6 Could not be determined | 28e. Plece of I building, | Injury - At hor etc. <i>(Specify)</i> | me, farm, stre | et, factory, office | 4 | 28f. Location (S City or Tow | treet end Numb n, Stete) | er or Rura | Route Number, | |
| | | dical | 29e. Certifler (Check only one) | Certifying Phys | ician: To the bes er: On the basis end manner | of exeminetic | riedge, deeth on and/or inve | occurred et the ti estigetion, in my | me, dete and plece, a opinion, deeth occurre | and due to tha co | ause(s) end me ate end pleca, | enner as steemed due to | eted. the cause(s) | |
| - 3 | 111 | P - | 29b. Signeture end 1 | tle of contiller | 1 | | | 29c. Lican | se number | 2 | 9d. Date signe | d (Month, L | Day, Year) | |
| | 0 | | 1 | 2 /e/ | eon, | 7 | 20 | D46 | 120 | | Sep ! | 7, 19 | 97 | |
| | | | 30. Name and addre | ss of person who co | mpleted cause of | deeth (Item | 23e) (Type, P | rint) | incre m | 10 21 | 23/ | | | |
| -3 | Stat | е | 31. Dete filed (Month | , Dey, Year) | 32. Regis | strar's Signet | S | | | | 100 | | | |

2Fb T T 1881

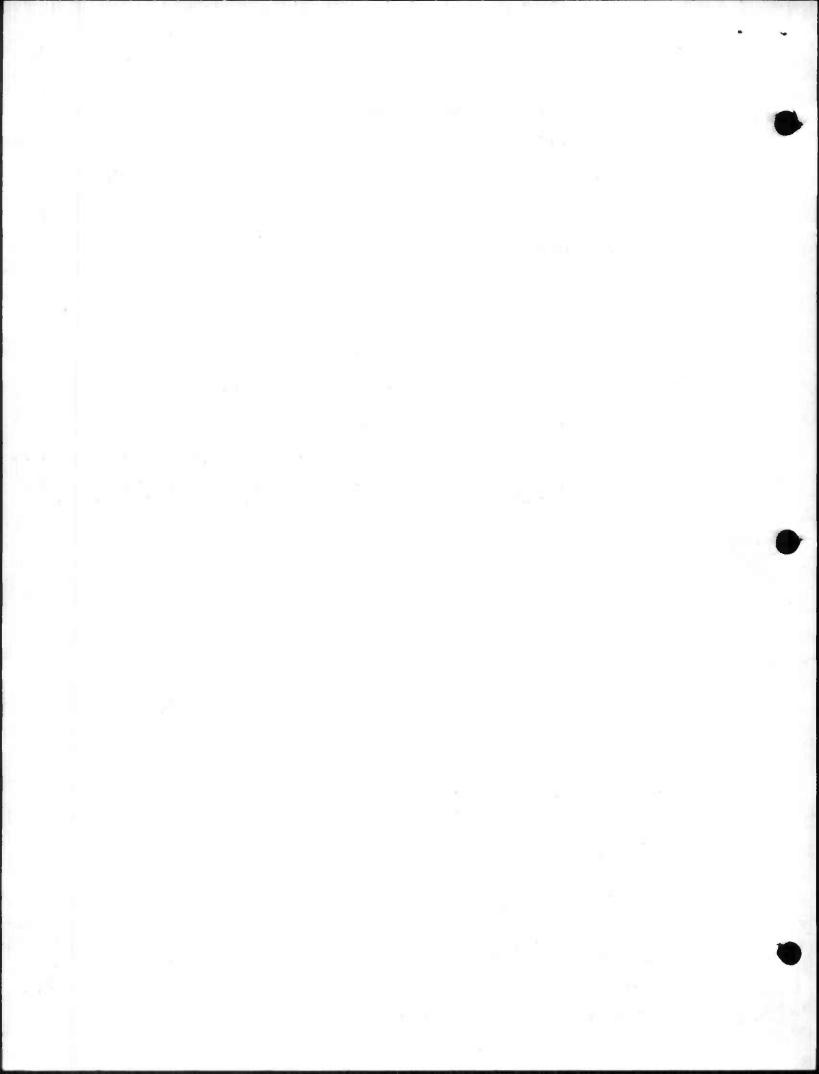
DHMH 16 Rev 6/95

5+VA



State of Maryland / Department of Health and Mental Hygiene 97

| | | | | | | Ce | rtifica | te of | Death | 1 | | Reg. No. | | | |
|-------------------|--|------------------|--|--|--|----------------------------------|--------------------------|-------------------------|----------------------------|--------------------------|-----------------------------------|---------------------------|-------------------------------|-----------------------------|--------------------|
| ı | | | 1. Decedent's Name (First, Middle, | Last) | | | | | | | 2. Date of D | eath | | | me of Death |
| ı | Physic | | | Everet | t Gra | int J | arvis | sTı | r. | | Month | nher C | 9, 199° | - | .00 A M |
| | /Medi Exami | | 4e. Facility Name (If not institution, | | | | ar vic | | | own, or Lo | cation of Dee | | County of De | | :00 A.M |
| 1 | EAGIIII | | 3622 Langrehr R | nad | | | | | Ro | ckda. | 10 | | Balti | | |
| | Funeral | | | . Sex | 7. Age (In yrs | . lest birthday | If Unde | r 1 Year | | 24 Hrs. | 8 Date of B | irth | - | | tate or Foreign |
| ò | Director | | 215-28-3894 Usual Residence of Decedent | 1 🛣 M 2 🗆 F | 66 | Yrs. | Months | Days | Hours | Min. | (Month, Danuary | ley, Year) | 1931 | Country) Maryla | and |
| | yland Man | | 10a. Stete 10b. County | | 10c. C | ity, Town or L | ocation | | | | | | | 10d. Insi | ide City Limits |
| | Se-f sh | ctor | | altimore | | Rock | dale | | | | | | | 1 🗆 | Yes 2 No |
| | be filed within 72 hours effer death with the Maryland niel Hyglene. Id other than "nature!", or items 23s or 28s-f show event, it's Medical Examiner must be notified at | Funeral Director | 3622 Langrehr Ro | oad | | | 10f. Zip | o Code | 2124 | 4 | | | en of What C | | |
| | dea | ner | 11. Marital Status | 12. Was Dece Armed Fo | edent Ever in U | J,S. 13. | Was Dece | dent of F | hispenic O | lgin? (Spe | ecify Yes or N Rican, etc.) | lo- 1 | 4. Race - Am | | an, |
| 21215-0020 | urs efte | by Fu | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 XYes | | | 1 ☐ Yes | | Specify | | riidaii, O(c.) | | Bleck, Wh | | |
| Õ | 2 hou | 8 | 15. Decedent's | | 1931 | | dent's Usu | al Occur | ation | | | 16h Kin | W I and of Busines | hite | |
| 15 | C 1 44 | Completed | (Specify only highest | grede completed) | | (Give | kind of wo | ork done | during mos | st of worki | ing | TOD. Kai | d Or Dusines | armoustry | |
| 212 | filed within Hygiene. ther than | E | Elementary/Secondary (0-12) | College (1 | -4or 5+) 5+ | | ssist | | • | 0000 | | | 201100 | | |
| | Hygi Hygi ent, | | 17. Father's Name (First, Middle, Le | | <u> </u> | | 22121 | ant | | | (First, Middle | | College Su <i>m</i> eme) | e | |
| lan | Mentel Mentel arked o | o Be | Fyo | rett Gra | ant In | rvis, | Cr. | | | | Mae | Seabo | | | |
| 7 | should be filed within and Mentel Hyglene. I marked other than urmatic event, it a M | 2 | 19a. Informant's Name/Relationship | | IIIC JO | | | c (Street | and Numb | | I Route Num | | | Zin Code) | |
| Maryland | parmit. Pages 1 and 2 should Department of Heelth and Men Important: If item 27 is marks any injury or other traumatic once. | | Mrs. Lillian Jar | | | | | | | | imore, | | | , ZIP COOB) | |
| re, | f Her fem othe | | 20a. Method of Disposition | | 20b. | Place of Disp | osition (Ner | me of | | | Date | 20c. Loc | cation - City o | or Town, Ste | te |
| Baltimore, | Pages nent of i ant: If ite | | XXBurial 2 ☐ Cremetion 3 4 ☐ Donetlon 5 ☐ Other (Spe | | State | cemetery, cre | | | | 1 0 | - 12 · | 1007 5 | Ti-o-i | M | 1 |
| | ortan | | 21. Signature of Funeral Service Lic | A | լսա | | ATTE) | | | | ot.12, | 1997 | limoni | um, M | aryland |
| Ba | parmit. Departrimporta any inju | | 1 Change of a | W KON | 2 | Î | oring | By | ers F | unera | al Dire | ectors | s, Inc | | |
| | | | Joseph | w year | nac | 87 | 728 Li | ber | ty Ro | ad Ra | andall: | stown | , MD 2 | 1133- | 4784 |
| | | | 23a. Part. Enter the disease, or co shock, or heart failure. List on | ly one ceuse on e | aused the dea ach line. | th. Do not en | ter the mod | de of dyln | ng, such as | cardiac o | or respiratory | arrest, | | | Il Between |
| ĵ. | Physician /Medical | | Immediate Course (Fig.) | | 1 | 1 | Λ | | 0 | | | | | Onset | and Death |
| | Examiner | | immediate Cause (Fine) disease or condition resulting in death) | a | 001 | ecta | l | | Cer | 1Ch | NOM | l- | | 160 | Month |
| п | | <u>_</u> | Todaling in addity | | Due to (| or as a conse | quence of): | | | | | | | | |
| Т | ed sit | line | | b | | | | | | | | | | | |
| | ertificete be executed ling physician end e as the buriel-transit | Examiner | Sequentially list conditions, if any, leading to immediate | | Due to (| or es e conse | quence of): | | | | | | | | |
| 68760, | be e ician burie | <u>a</u> | Cause (Disease or Injury | C | | | | | | | | | | | |
| 387 | phys the | Medical | that initiated events resulting in death) Last | | Due to (d | or es a consec | quence of): | | | | | | | | |
| ŏ | | | | d | | | | | | | | | | | |
| m m | law requires that the death certies been signed by the attendines 2 should be deteched for use | Physician | Pert II. Other significant conditions | contributing to de | ath but not res | sulting in the u | nderlying c | ausa niv | en in Part | 1 | 23h Did | I tobacco u | una contribut | te to the ce | uee of death? |
| o. | by th | h | Control of the contro | | | | , , , | | | | | | 1 | | 4 Unknown |
| | s tha | Бу Р | | | | | | | | | '- | 100 20 | (110 311 | TODADIY | 4 Unknown |
| Records, | quire in sig uld b | | | | | | | | | | | s en eutops | sy 24b | | psy findings |
| 00 | w require been si should | let | | | | | | | | | pert | ormed? | | available p | nor to of cause |
| Re | 0 - 0 | Completed | | | | | | | | | | | , | of death? | |
| ā | | | 25. Was case referred to medical | | | | | | | | 1 | Yes 25 | No | 1 🗆 Yes | 2 No |
| 5 | certi | Be | examiner? | Hospital: | | U -, -,- | 117.30 | Oth | OF: | | (Check only | | | | |
| ō | Phys this ral di | . To | 1 Ves 2√ No 27. Manner of Deeth | 1 Ir | | ER/Outpatier | | M | 4LI NI | | ne 5D Res | | | ecify) | |
| Division of Vital | Attending Physician: or death. ector: After this certific by the funeral director, | Certification: | 1° Natural 5 ☐ Pending | | h, Dey Year) | 28b. Time o Injury | M | 8c. Injun | ye≀ k? Yes 2□ | | 28d. Describe | now injury | occurred | | |
| S | Attender deat ector: | Ca | 3 Suicide 6 Could not | be as s | of Indiana At h | | | | 163 2 | | nos I academ | (0) | | 10 | |
| 2 | 교육등등 | ŧ | 4 ☐ Homicide determine | d Zoe. Flace | of Injury - At h g, etc. <i>(Specil</i> | ome, tarm, sti fy) | eet, factory | , office | | 1 2 | 28f. Location City or To | (Street end wn, Stete) | Number or F | dural Houte | Num <i>ber</i> , |
| | pital Surs eral filled | | 200 Cartillar et Cartetans | | | | | | | | | | | | |
| | To the Hospital or within 24 hours aft to the Funeral Dir completely filled in | edical | 29a. Certifier 1 Cartifying F (Check only one) 2 Medicai Exi | hysician: To the barriner: On the barriner | sis of exemina | wiedge, death ition and/or in | occurred vestigation, | at the tim , In my o | ne, date an pinion, dea | d place, a th occurre | ind due to the ed at the time, | cause(s) e dete and p | ind manner a plece, and du | is stated. le to the cau | use(s) |
| | Within 2 To the comple | N N | 29b. Signature and title of certifier | OII III III | er steted. | | 290 | License | e number | | | 20d Date | planed /Man | th Day Va | 0.6) |
| | 8 4 8 4 | | A A | <u></u> | | | 200 | | / 1/ | 0/ | | 250. Date | signed (Mon | , Day, 18 | - 7 |
| 1 | 20 | | Janel | Cra 15 | N 1 | WI) | | y4 | 611 | 8 | | set. | 1 /1 | ,19 | 17 |
| (| XX | | 30. Name and address of person who | completed cause | of deeth (Item | n 23e) (Type, | Print) | , | 1. | 0 - | 1 | H | 11 | / | 21093 |
| | 9 | | 31. Date filed (Month, Dey, Year) | 2014 | MD | 141 | FT ' | YOY | K | KD | Ly | inevi | Jille | MD | 21093 |
| | Sta Registr | | | | Davidson- | Muse earn | | 1 | | | | | | | |
| - | riegisti | all | SEP 1 1 1997 | Juna | nantazon- | - Manaelle | jk | | | | | | | | |



State of Maryland / Department of Health and Mental Hygiene

| | 1 | | | Otate of W | aryland | | tificate of | Death | | Reg. No. | 37 | 27495 |
|--------------|--|-----------------|--|---|-----------------|--------------------------------------|---|---|-------------------------------------|-----------------------------------|--------------------------|--|
| | Physic /Medi Exami | cal | Dacedant's Nama (First, Middla, La HELEN 4a. Facility Nama (If not institution, given | J | OINER | | | 4b. City, Town, or | | Day er 6, 1 | | 3. Tima of Death 2:00 P.M. |
| | Funeral | | Augsburg Luthers 5. Social Sacurity Number 6.5 | n Home | ja (In yrs. les | st birthday) Yrs. | If Undar 1 Yaar Months Days | Lochea | 8. Data of Birt | Ba1 | timo1 | lace (Steta or Foreign |
| | · · | _ | Usual Rasidance of Decadant 10a. Stata 10b. County | | | Town or Lo | cation | | June 13 | 1903 | | vland Od. Insida City Limits |
| | with the Ma 3e or 28a-f | i Director | Maryland Baltimo | | | Loche | 10f. Zip Coda | , | | 10g. Citizan of \ | What Coun | 1 ☐ Yas 2 ☒ No try? |
| 020 | 7.72 hours efter death with the Maryland "natural", or items 236 or 28a-f show folice! Examiner must be notified at | by Funeral | 6811 Campfield Ro 11. Marital Status 1□ Navar Marriad 2□ Married 3 ☼ Widowad 4□ Divorced | 1 • 12. Was Dacedant Armed Forces? 1 □ Yas 2 ☑ If Yas, Giva Yaar or Datas: | | | 21207 Vas Dacedent of F Yas, specify Cub | Hispanic Origin? (S an, Maxican, Puert | pecify Yas or No- o Rican, atc.) | USA 14. Rac Blac Specify | e - Amaric ck, Whita, | atc. |
| 0200-91212 | within 72 ene. then "ne! | Completed | 15. Dacedant's E (Spacify only highest gra Elamentary/Secondary (0-12) unknown | ducetion ida complatad) Collaga (1-4or t | 5+) | 16a. Daced (Give life. L | OO NOT use ratire | pation during most of wor d) | king | 16b. Kind of Br | - | |
| yland | be filed ntal Hyg of other event, | To Be C | 17. Fathar's Name (First, Middle, Last, | | Waltz | | | 18. Mother's Nan | ne (First, Middla, Cora M | Maidan Suman | , | |
| Mar | nd 2 shouth end 27 is me r trauma | | 19a. Informant's Name/Ralationship (| Type, Print) (Great Nie | ce) | 423 E | laverhil] | and Numbar or Ru | oppa, MI | | | Code) |
| Baltimore, | permit. Pages 1 and Department of Haalt Important: If Item 27 any Injury or other 1 once. | | 20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Othar (Specif | | | | sition (Name of netory or other pla Memoria | ce) | Data | 20c. Location - | | wm, Stata e, Maryland |
| Rall | Demit Depart Import any In | | 21. Signatura of Funaral Sarvice Licer | 40 | | Lc 87 | 28 Liber | ers Funer | Randalls | town. M | | 21133 |
| , | Physician /Medical Examiner | 16 | 23a. Pagr. Entar the disaasa, or com sheck, or haart failura. List only Immadiata Cause (Final disaasa or condition resulting in daath) | | | RONA | my Tith | ng, such as cardiac | | rest, | | Approximate interval Batwean Onsat and Death |
| 00/00 | tificete be executed g physician and es the buriel-transit | edical Examiner | Saquantially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last | c | Dua to (or a | | | | | | | |
| DOXO | ipu Pipu | 90 | L | d | | | | | | | | |
| | r requires that the deeth cer been signed by the ettendir should be detached for use | / Physician/ | Part II. Other eignificant conditions of | | | ng in tha un | darlying ceuse giv | van in Part I. | | obacco use con res 2 No | | the cause of death? |
| records, | M W CV | Completed by | Rheimatoid | Arteni | hs | | | | 24a. Was a | an autopsy med? | ave | re eutopsy findings illabla prior to nplation of cause laath? |
| VII I | in: The | Be Cor | 25. Was cesa rafarred to medical | | | | | 26. Place of Dea | | es 2010 | 1□ | lYas 2□ No |
| VISION OF VI | To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2 | ို | axaminar? 1 Yas 2 No 27. Manner ol Death 1 Natural 5 Panding 2 Accident invastigation | Hospital: 1 Inpatie 28a. Data of Injur (Month, Dep | ry 28 | VOutpatiant Bb. Tima of Injury | 28c. Injur Wor | er: 4 Nursing H | oma 5 Rasid 28d. Describe h | ence 6 □Oth | |) |
| SIAIO | Ital or Atta | Certification: | 3 ☐ Suicida 6 ☐ Could not be datarmined | building, etc | : (Specify) | | | | 28I. Location (S City or Tow | n, Stete) | | |
| | To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A complataly filled in by the fu | Medical | one) 2 Medical Exam | ysician: To the bast of linar: On the basis of and mannar sta | examination | idga, daath n and/or inv | astigation, in my o | pinion, death occui | rred at the time, o | lata and place, a | and dua to | tha ceuse(s) |
| 1 | 2328 | | 29b. Signatura and title of certifier Deburah | Dierre | 00 | | 29c. Licans | 110 | | eplem | | |
| | M | | | ence 72 | eath (Itam 23 | 3a) (Type, F | KHEIS | guts Ave | . Ba | Ito. L | () : | 9,1997 |
| | Sta Registr | - | 31. Day (Month, Day Year) | Julia Pavis | lor Par | nde lli | | | | | | |

DHMH 16 Rev 6/95

- Tale - Tale C erg i

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Day Yeer Meya Μ. Kekich 8:30 AM Sept 9 1997 4a. Facility Nama (If not institution, giva straat and numbar) 4b. City, Town, or Location of Death 4c. County of Death 1930 Merritt Blvd. Dundalk Baltimore If Undar 24 Hrs. Hours Min. If Undar 1 Year 5. Social Sacurity Numbar 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) Days Months 1**X** M 2□ F 215-05-1323 82 Oct 26 1914 Maryland Usual Rasidanca of Dacadani 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Md. Baltimore 1 ☐ Yas 2 XNo Dundalk 10e, Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? 1930 Merritt Blvd. 21222 USA 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 X No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black. Whita, atc 1 Navar Marriad 2 Married 1 ☐ Yas 2 📉 No Spacify: Specify: 3 Widowad 4 Divorced White 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collage (1-4or 5+) Aircraft mechanic Defense 12 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maldan Sumema) Wasa Kekich Rosa Yelikek 19b. Mailing Addrass (Straat end Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Neme/Ralationship (Type, Print) Mary Kekich / wife 1930 Merritt Blvd. Baltimore, Md 21222 20b. Pleca of Disposition (Nema of 20a. Mathod of Disposition Data 20c. Location - City or Town, State cematary, crematory or other pleca) 1 XBurial 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Spacify) Holly Hill Memorial 9-12-97 Middle River, Md. 21. Signatura of Funaral Sarvica Licansea 22. Nama and Addrass of Facility Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 23a. Pa 1. Entar tha dispersa, or complications that causad the shock, or haart fail free List only ona causa on aach line. Approximata Intarval Batween Onsat and Death Do not antar tha mode of dying, such as cardiac or respiratory arrest, Immedieta Causa (Final disaasa or condition rasulting in daath) blemia Ominotes Dua to (or as e consequence of): ermonia Sequantially list conditions, if any, laading to Immadiata causa. Entar Undarlying Cause (Diseese or Injury that initieted avents rasulting in daath) Last Dua to or as a consequance of): 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Wera eutopsy findings availabla prior to 24a. Was an autopsy performad? complation of causa of death? 1 🗆 Yas 2. No 1 ☐ Yas 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

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Director

28a-f show

ò 238 Director

Funeral

by

Completed

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event, the Medical Examiner mant be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 234 enty injury or other traumatic event, tra Mooica Examiner must once.

Baltimore, Maryland 21215-0020

the Meryland

Physician/Medical Examiner buriel-trer anding physician use as the bune to ed by the a detached f signed t þ page 2 should Completed Hospital or Attending Physician:
hours after death.
Funeral Director: After this certificative filled in by the funeral director, in filled in by the funeral director, in the funeral director, in the funeral director, in Be 2 Certification:

certificate

2

1 1 2

The lew requires that the death cartificate be executed

Box 68760.

P.O.

Records,

Division of Vital

Pert II. Other eignificant conditiona contributing to death but not resulting in the underlying cause given in Part i. 25. Was case raferred to medical 26. Place of Daath (Check only one) Othar: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred 1 Natural 5 Panding invastigation 1 Yas 2 No 2 Accidant 3 ☐ Suicida 6 Could not ba 28e. Place of Injury - At home, farm, streat, factory, office building, atc. (Specify) Location (Straet end Number or Rural Route Number, City or Town, Steta)

29a. Certifiar

Medicai

4 Homicida

1 Cartifying Phyeician: To tha best of my knowledga, daath occurred at the time, deta and placa, and dua to tha causa(s) and manner es steted.

| Medical Examinar: On the basis of exemination and/or investigation, in my opinion, death occurred et the tima, dete and place, end due to tha ceuse(s) and mannar statad.

RD1926

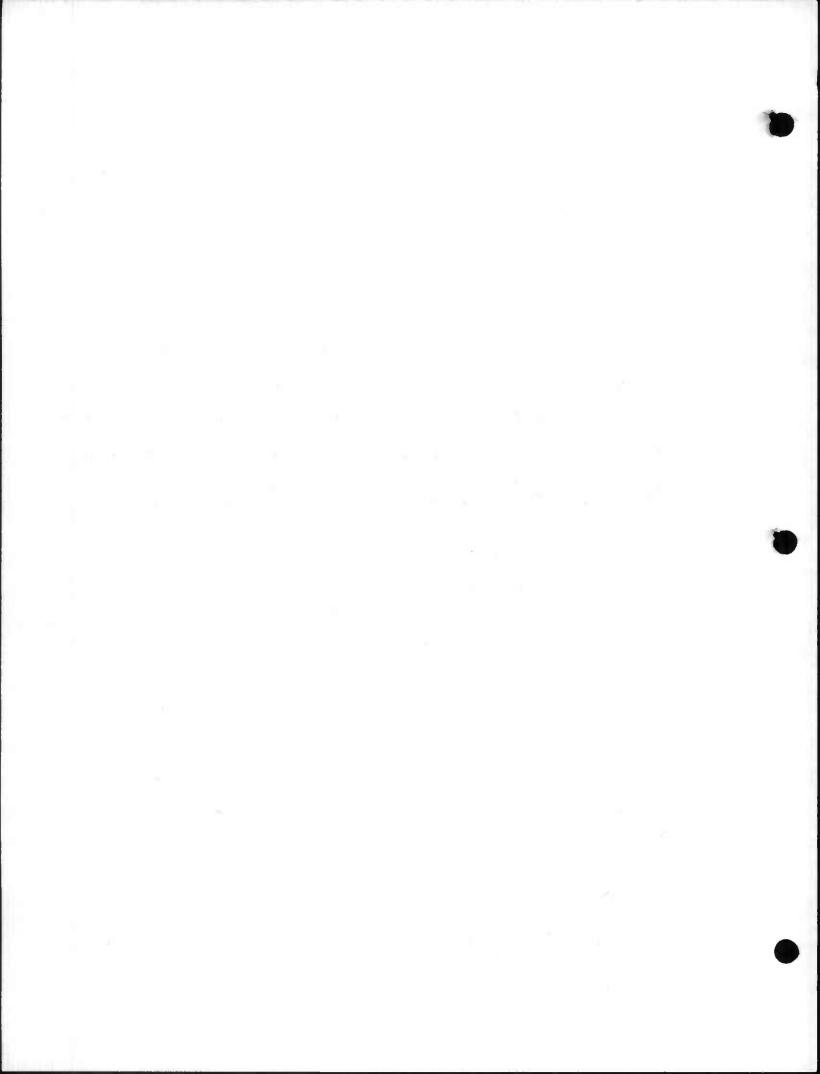
29b. Signatura and titla of certified

29c. Licansa numbar 29d. Data signed (Month, Day, Yaar)

30. Nama and address of person who complated cause of death (Item 23e) (Type, Print)

9000 Franklin Square Dr. John Kim, M.D. Baltimore, Md 21237

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Items20b,20c 9-11-97 FilmG751 W.H.Per F/H Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 805 KOENIG Month **Physician** SEPTEMBER /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, 4c. County of Deeth Examiner LONGGREEN NURSING CENTER GENESI if Under 1 Year | if Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthdey) 9. Birthplece (State or Foreign **Funeral** Deys Months 11XM 2□ F 85 SEPT. 14", 1911 NEW YORK Director 324-03-0111 Usuel Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f show. MD N/A 1 Yes 2 No BALTIMORE Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 115 EAST MELROSE AVE. 21212 USA Funeral filed within 72 hours efter death 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No If Yes, Give Yeer or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify by Specify. WHITE 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry el Hygiena. Elementery/Secondary (0-12) College (1-4or 5+) ATTORNEY AT LAW 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) 12 should be fill hend Mentel H Be **AARON** 2 COHEN **JENNY** SCHOENBACH 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 si Department of Health end Important: If item 27 is n any injury or other traur TERRY KOENIG (SON) 603 EAST 30TH ST. 21218 BALTO. MD 20a. Method of Disposition 20c. Location - Towson, MD 1 Buriel 2 Cremetion 3 PRemovel from State Hillton Service Corp 9-9-97 ARLINGTON HEIGHTS, I 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service License 22. Neme end Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 23e. Pert1. Enter the disease, or confplications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or hear feilure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting In death) Examiner Examiner 100 be executed Sequentielly ilst conditions, if eny, leeding to Immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Box 68760. physician Physician/Medical The law requires that the death certificate Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 robably 4 Unknown þ 24b. Were autopsy findings avelleble prior to completion of ceuse of death? Completed 24e. Wes en eutopsy performed? this certificata 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physicien: after death. Director: After this certific Be 25. Wes cese referred to medical examiner? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home Certification: To 1 Yes 2□No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manney of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Naturel 5 Pending 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 4 Homicide 24 hours a 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end manner as steted.

State Registrar

To the

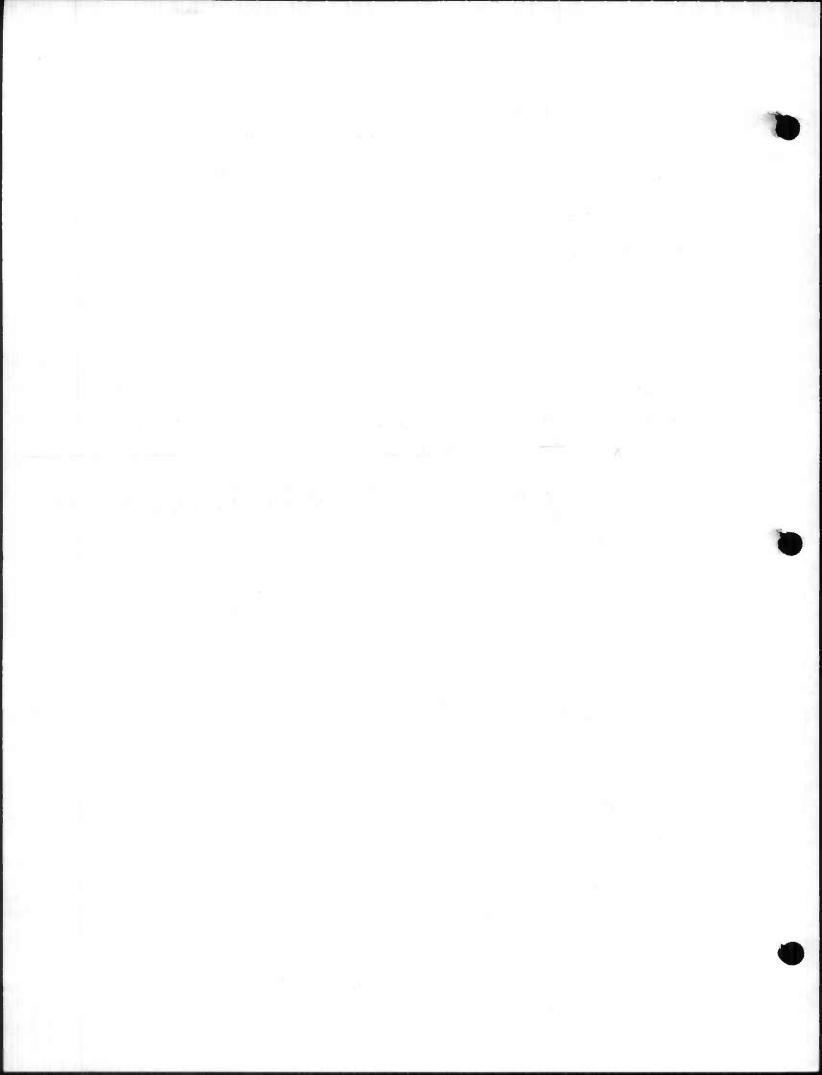
31. Date filed (Month, Day, Year) SEP 11

30. Name and eddress of person who cor

(Check only one)

HOLABIRD AVE. BALTO. MD. 21222

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and my inner stated.



State of Maryland / Department of Health and Mental Hygiene

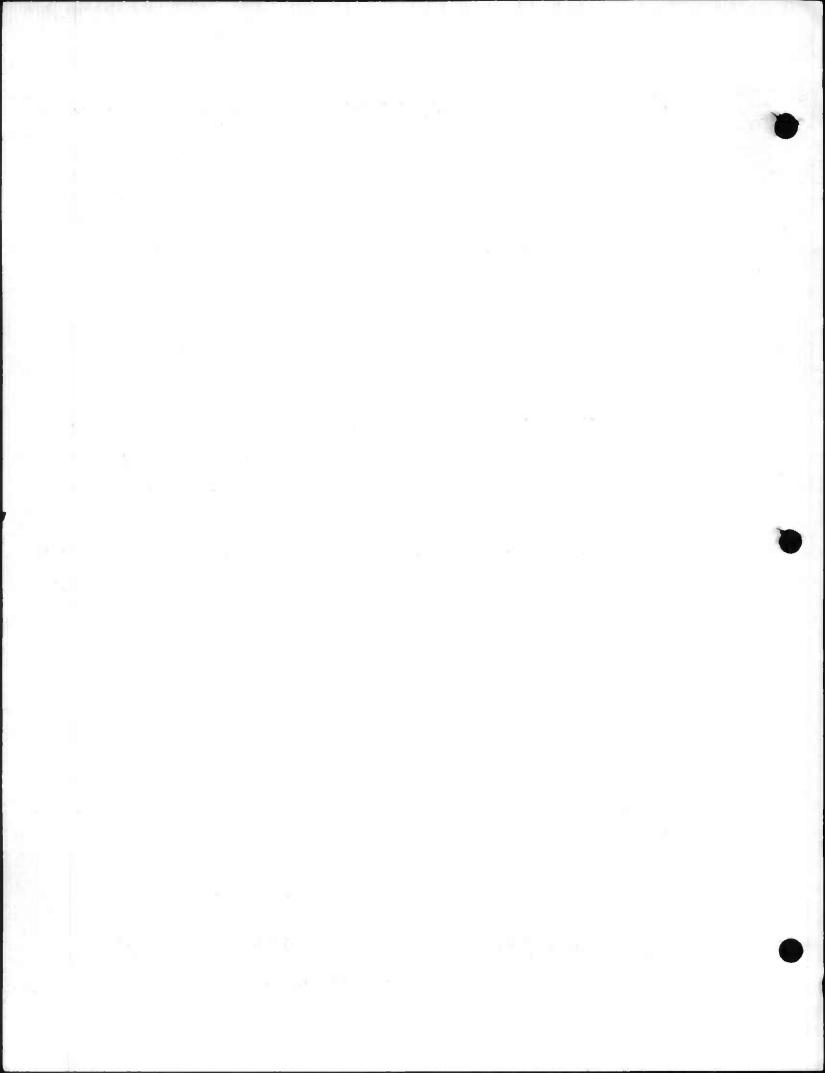
27498 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** LA GRAVE Month 10815 8 1997 4c. County of Death /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner 7. Age (In yrs. last birthday)
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9. Birthplece (State of Day) Joseph Richey Hospice 5. Sociel Security Number Funeral 212-36-5379 1 ☐ M 2 🖫 F Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 23a or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Director MD N/A 1 Yes 2 No Baltimore 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 236 S. Collington Ave. 21223 USA Funeral Rema 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. permit. Pages 1 end 2 should be filed within 72 hours after l Department of Heelth end Mental Hyglene. Important: if item 27 is marked other than "natural", or iten any injury or other traumatic event, an Mexical Examina 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0020 1 ☐ Yes X ☐ No Specify: Specify: White À 3 □ Widowed 4 Divorced Year or Dates: Be Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled N/A 17. Father's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Maiden Surname) William Gress, Sr. 2 Mamie Walsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzanne McCormick/Social Worker 2400 Broening Hgwy., Suite 180 Balto., MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) Metro Crematory, Inc. 9/10/97 Baltimore, MD
22. Name and Address of Fecility 21. Signature of Funaval Service Licensee Cremation Society of Maryland, Inc. Dawn F. McDonald

299 Frederick Rd. Baltimore, MD 21228

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest,

Approximate Interval Between Onset and Death Physician /Medicai mmediate Cause (Final 6 MONTHS METASTATIC CARCINOMA BREAST TO LUNG disease or condition resulting in death) Examiner Due to (or es a consequenca of): Physician/Medical Examiner CARCINOMA BREDST YEAR The law requires that the death certificate be executed physician and s the buriel-trens Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initioted events resulting In deeth) Lest Due to (or es a consequença of Box 68760. Due to (or as e consequence of) USB es 10 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t Records, þ 24b. Were autopsy findings avelleble prior to completion of cause of death? Completed 24a. Wes en autopsy page 2 s certificate hes 1 ☐ Yes 2 TNo 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 212 No this 27. Manner of Deeth 1 Natural 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred efter death. Certification: 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Sulcide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2 4 Homicide led in the Fugeral Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, dete end place, and due to the ceuse(s) and manner as steted.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29a. Certifier (Check only one) 29b. Sign 29c. License number 29d. Dete signed (Month, Day, Year) margthur xx 06933 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) READSI JOHN & MACGIBBON 101 W BALTMORE 21201 31. Date filed (Month, Dey, Year) 32. Registrar's Signature Telle Davidson-Randelle Registrar SEP 1 1 1997

DHMH 16 Rev 6/95

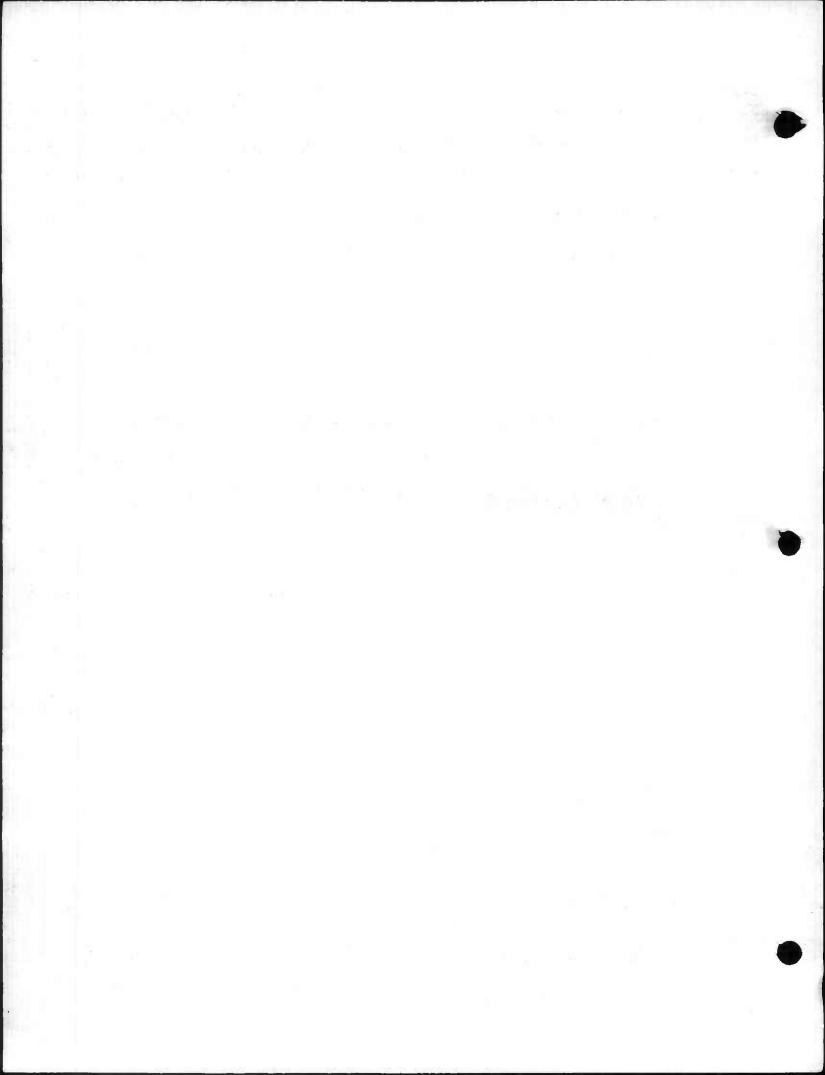


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

271.00

| | | | | State of Ma | - | Certificate of | | wieiliai ny | Reg. No. |) [| 21499 |
|---------------------|---|---------------------|---|--|--------------------|---|---|--------------------------------------|------------------------------------|---------------------------------------|---------------------------------|
| п | Diameter) | | 1. Decedent's Name (First, Middle, La | ist) | | | | 2. Date of De | | V | 3. Time of Death |
| | Physic: /Medi | | CARN4THIA | 4 | EE | | | SEPT G | Day | Year 1997 | 2:22 AN |
| | Examir | | 4a. Fecility Name (If not institution, given | | | | 4b. City, Town, or I | | | | |
| | | | JOHNS HOPKINS | BAYVIEL | MED | CAI CTR | BALTIL | MCRF | BALT | uno P | 6 CITY |
| | Funeral | | 5. Social Security Number 6. 5 | Sex 7. Age | (In yrs. lest birt | hday) if Under 1 Year | If Under 24 Hrs. | 8 Date of Ri | rth | 9. Birthpi | iece (Stete dr Foreign |
| н | Director | | 248 10 5113 | 1□M 2XF 87 | 7 | rs. Months Days | Hours Min. | July 6 | 7 1910 | South | Carolina |
| | 9 | | Usual Residence of Decedent | | | | | | | | |
| | ahow d a | _ | 10a. Stete 10b. County | | 10c. City, Towr | | | | | 10 | Od. Inside City Limits |
| | death with the Maryland ms 23a or 28a-f show rnust be notified at | cto | Maryland Harford | | Edgewo |)OQ | | | | | 1 ☐ Yes 2 ☑ No |
| | 10 th | E e | 10e. Street end Number | | | 10f. Zip Code | | | 10g. Citizen of | What Coun | try? |
| | 23a | a | 608 Dogwood Avenue | 2 | | 21040 | 0 | | U.S. | A. | |
| Maryland 21215-0020 | or he | by Funeral Director | 11. Maritai Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced | 12. Wes Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes: | | 13. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ◯XNo | | pecify Yes or No o Rican, etc.) | | ce - America ck, White, e phite | |
| 5-0 | n 72 hours | ted | 15. Decedent's E (Specify only highest gra | ducation | 16a. | Decedent's Usuel Occur (Give kind of work done | pation | klas | 16b. Kind of B | usiness/Ind | lustry |
| 21 | within lene. than "r | Completed | Elementary/Secondary (0-12) | College (1-4or 5+ |) | life. DO NOT use retire | during most or work od) | king | | | |
| 2 | | Con | 12 | | Pac | ker | | | Distill | lery | |
| Pu | I and 2 should be filed v Health and Mental Hygie sen 27 is marked other t | Be | 17. Father's Name (First, Middle, Last, Charles Worthy |) | | | 18. Mother's Nam | | | ne) | |
| yla | should be ind Mental I | 2 | Charles worthly | | | | Hattie | Mae Le | e | | |
| Jar | Cl 20 22 68 | | 19a. Informant's Name/Reletionship (| | 1 | Meiling Address (Street | | | | | Code) |
| | s 1 and 2 of Health Nem 27 i | | Barbara G. Berry | (Daughter) | | Dogwood Av | venue Edg | ewood, | Md. 2104 | 10 | |
| Baltimore, | 8 = 5 | | 20a. Method of Disposition 1 🙀 Burial 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Specif | | cemeter | Disposition (Name of c, crematory or other ple Mem. Garde | ns 9/1 | Dale 1/1997 | 20c. Location - Belair | | wn, Siele |
| Ball | permit. Pa Departmer Important: any injury stics. | | 21. Signature of Funeral Service Licer | z ka u ko | | 22. Name and Address Bruzdzins 1407 Old I | ci Funera | 1 Home | P.A. | 1 213 | 221 |
| | | | 23a 11. Enter the disease, or com lock, or heart failure. List only | plications thet caused the | ne death. Do n | ot enter the mode of dyi | ng, such as cardlac | or respiretory a | rrest, | 4. 212 | Approximate Interval Between |
| 4 | Physician | | prock, or rieart failure. List only | one cause on eech line | , | | | | | | Onset end Death |
| 4 | /Medical | | Immediate Cause (Finel disease or condition | PES | PIRAT | ORY FAIL | . RE | | | 1 | 3 0015 |
| П | Examiner | | resulting in death) | a. D | ue to (or as a c | onsequence of): | 0,00 | | | 1 | 7,775 |
| _ | D # | ner | | | | r45CUCAR | Acch | GW T | - | - | 2 CHAS |
| | icate be executed physician and s the burial-transit | Examiner | Sequentially list conditions, | | | onsequence of): | | , , , | | | July 3 |
| 0 | ificate be executing physician and as the burial-tran | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events | | | | | | | į | |
| 68760, | ate b hysic he b | edical | that initieted events resulting in death) Lest | C. Du | ue to (or as a c | onsequence of): | | | | 1 | |
| | E 0 6 | | | | | | | | | 1 | |
| Box | th ce tendi | and | | d | | | | | | | |
| | the att | sici | Part II. Other significant conditions of | ontributing to deeth but | not resulting In | the underlying cause gi | ven in Part I. | 23b. Dld | tobacco usa co | ntributa to | the cause of seath? |
| P.0 | requires that the death cert een signed by the attendin hould be detached for use | Physician/M | IA L | ./- | 1 | ^ | | 10 | Yes 2□ No | 3 Prob | ably 40 Unknown |
| | gned be de | by | - 19 f' | rator | Thei | ner a | | | | | |
| brd | v require been si should | P P | Hyre | 2 2 1 | | | | | an autopsy | 24b. We | re eutopsy findings |
| Records, | - D 00 | Completed | | 1 Ma The | Ma | | | pont | J | con | npletion of cause leath? |
| | lcian: The lav certificate has rector, page 2 | E | 4/10 | enthony | | | | 10 | Yes 2□No | 1 10 | Yes 20 No |
| Vital | an: tifica tor, p | Bec | 25. Was case referred to medical | 01/10/101 | ·u | | 26. Place of Dee | | | | 2,5710 |
| > | Physician: The lav this certificate has ral director, page 2 | 일 | examiner? | Hospitel: | 2 ER/Out | patient 3 DOA Oth | her: | | dence 6 □Oth | er (Specify | 1 |
| 101 | 문 문 등 | | 27. Manner of Deeth | 28a. Date of Injury | 28b. T | me of 28c. Inju | | | how injury occur | | / |
| Division | or Attending lafter death. Director: After in by the fune | ate | 1 ☐ Naturel 5 ☐ Pending 2 ☐ Accident Investigation | (Month, Day) | ear) (r | | Yes 2 □ No | | | | |
| Nis. | Atte or de by th | 2 | 3 ☐ Suicide 6 ☐ Could not be determined | 20e. Place of injury | - At home, far | m, streel, factory, office | i i | 28f. Location (| Street and Numb | er or Rural | Route Number, |
| ā | after Direct | Certification: | 4 Homicide | building, etc. | (Specify) | | | City or To | wn, State) | | |
| | n 24 hours | edical | 29a. Certifier 1 ☐ Cartifying Ph (Check only one) | ysician: To the best of entire: On the basis of entire and menner state | xaminetion and | death occurred et the ti /or investigetion, In my d | me, date and placa, opinion, deeth occur | , and due to the red at the time, | cause(s) end ma dete and place, | end due to | ated. the cause(s) |
| | 250 | Σ | 29b. Signature and fulls of certifier | | | 29c. Licens | se number | | 29d. Date signe | d (Month, E | Day, Year) |
| | | | MAN UP | IMPR | 114 | 960 | m^2 | | SCPTEM | RAD | 91097 |
| | | 1 | 30. Neme end/áddress of person who | completed cause of dea | th (Item 23e) (| (voe Print) | | - | - I I GM | 1 | 1/(7() |
| | | | JENOWIAL COME | JIMB RIL | THEM | (. 4940 E | ASTERN A | LUE. | BALT: 1 | 11 1 | 21724 |
| | Sta | te | 31. Date filed (Month, Dey, Year) | 32. Registrar | s Signature | | 710. | 100, | 1 | 11 / | -, -, |
| | Registr | ar | SEP 1 1 1997 | Julia David | lson-Aano | ندو | | | | | |

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State of Maryland / Department of Health and Mental Hygiene

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| | | | | Cei | rtificate of | Dealli | | Reg. No. | | |
|------------|---|---|--|--|--|--|---|--|--|--|
| | 1. Decedent's Name (First, Midd | le, Last) | | | | | 2. Dete of De Month | - | Year 3. | Time of Death |
| an al | SOOK | Te Lee | | | | | Septem | | 1997 | 1145 pn |
| _ | 4a. Facility Name (If not institution | n, give street end num | n <i>ber)</i> | | | 4b. City, Town, | | | | |
| | Lorien Nursin | g Home | | | | | | Howa | rd | |
| | | | | | | | Irs. 8. Date of Bi | rth e <i>y, Year</i>) | 9. Birthplace | (Stete or Foreign |
| | | TO M ZCX | 72 | Yrs. | | | | | Korea | |
| - | | , | 10c City | Town or Lo | cation | | | | 104.1 | nside City Limits |
| 5 | Total Tiles | | | | ourion. | | | | | Yes 2() No |
| ect | | <u> </u> | 001 | OIIIOZG | 404 71- 0-4- | | | 40-044 | | |
| ral Dir | | ane | | | | | | 100 | | |
| | 11. Marital Status 1 □ Never Married 2 □ Mar | Armed For | rces? 2 📉 No | l I | f Yes, specify Cu | ban, Mexican, Pu | (Specify Yes or Nerto Rican, etc.) | Blac | ck, White, etc. | |
| | 3 Widowed 4 Divorced | Year or Da | ates: | | 270 | э ороону. | | Зреспу | Kor | rean |
| ete | 15. Deceder (Specify only highe | nt's Education st grede completed) | | (Give : | kind of work done | e during most of v | working | 16b. Kind of B | usiness/Industr | у |
| du | Elementary/Secondary (0-12) | College (1 | -4or 5+) | | | ed) | | | n . | |
| | | (not) | | Sean | stress | 10 Mathada h | Jama /First Middle | | | ess |
| m | | | | | | | | | 10) | |
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| 1 | | 5011 | 20b. Pl | ace of Dispo | sition (Neme of | | 1 | | | |
| | 1 N Burlal 2 ☐ Cremation | | State | metery, cren | netory or other pi | | | | | |
| - | | | Mea | | | | 9/97 | FIKTIO | ge, Ma. | |
| | 21. Signature of Furieral Service | Licensee | 00 | | | | neral Ho | me at Me | adowric | dae MP |
| | teven | Hund | _ | | * | | | | | 0 |
| | 23a. Part1. Enter the disease, of shock, or heart feilure. List | complications that ca | aused the death ach line. | Do not ente | er the mode of dy | ring, such as card | dac or respiratory | errest, | App | proximate erval Between |
| | | | | | | | | | | set and Death |
| | Immediate Cause (Finel diseese or condition | ille | emiai | | | | | | | 2 weeks |
| | resulting in death) | a | Due to (or | as e conseq | uence of): * | | | | | |
| ne l | | - Chr | nu i | Penal. | Failer | rl | | | | 4 months |
| хаш | Sequentially list conditions, | | Due to (or | as a conseq | uence of): | | | | | |
| | cause. Enter Underlying Cause (Disease or Injury | · Du | retes | mel | letus | | | | / | 2 years |
| dice | that initieted events resulting in death) Lest | 0 | Due to (or | as a consequ | uence of): | | | | | 0 |
| Me | | | | | | | | | | |
| lan | | u . | | | | | | | | |
| Sic | | | | | nderlying ceuse g | Iven in Part I. | 23b. Dld | tobacco use co | ntribute to the | cause of death? |
| P | Casolisan | ulas a | 1 Ni Nort | _ | | | 1 | Yes 2 No | 3 Probably | 4 Onknow |
| Ď | www. | acar o-c | - Come Le | | | | | | | |
| eted | Deulitus | Ellers | | | | | 24e. Wes | s an autopsy ormed? | eveilab | tion of cause |
| m d | 2/11/2 | * | | | | | | · | | |
| | regres une | in | | | | | | | 1 L Ye | s 2□ No |
| ă | examiner | Hospital: | | | 0 | | | | | |
| | | 101 | | | 1 3LI DOA | 4 Mursin | | | | |
| 盲 | | g (Monti | h, Day Year) | Injury | | | 200. 200000 | non injury occur | | |
| l Ca | 3 ☐ Suicide 6 ☐ Could | not be | of Injury - At hor | ne farm stre | | | 28f. Location | Street and Numb | ner or Rural Ro | ute Number |
| er | 4 ☐ Homicide determ | buildin | ng, etc. (Specify) | , , , , , , , , , , , , | oot, ractory, cince | • | City or To | wn, Stete) | | |
| | 29a. Certifier 1 Certifyin | g Phyelclan: To the | sis of examination | ledge, death on end/or inv | occurred at the trestigetion, in my | time, date and pla opinion, death or | ace, and due to the | ceuse(s) end me date and place, | enner es stated and due to the | l. |
| dical | (Check only 2 Medical | examiner: On the ba | or etgland | | | | | | | cause(s) |
| ledic | (Check only 2 Medical one) | and mann | er stated. | | | | | 29d. Date signe | d (Month Dev | |
| Garage III | (Check only 2 Medical | and mann | er stated. | | 29c. Licer | 14782 | | 29d. Date signe | | Year) |
| | To Be Completed by Physician/Medical Examiner To Be Completed by Funeral Director | 4a. Facility Name (If not institution Lorien Nursing Schools Security Number 454-41-2640 Usual Residence of Decedent 10a. Stete 10b. County Md. How 10e. Street and Number 6334 Cedar Latter 11. Marital Status 1 Never Married 2 Maria 3 Widowed 4 Divorced (Specify only higher Elementary/Secondary (0-12) 6 17. Father's Name (First, Middle, Unobta 19a. informant's Name/Relations Chung Lee - 20a. Method of Disposition 1 M Burlal 2 Cremation 4 Donation 5 Other (Security only higher 19a. Informant's Name/Relations Chung Lee - 20a. Method of Disposition 1 M Burlal 2 Cremation 4 Donation 5 Other (Security only higher 19a. Informant's Name/Relations Chung Lee - 20a. Method of Disposition 1 M Burlal 2 Cremation 4 Donation 5 Other (Security Name (Fined disease or condition resulting in death) 23a. Part 1. Enter the disease, of shock, or heart feilure. List Immediate Cause (Fined disease or condition resulting in death) 25a. Part II. Other algnificant condition familiated events resulting in death) Lest Part II. Other algnificant condition for that intelled events resulting in death) Lest 25. Was cas for the disease of Injury that intelled events resulting in death) Lest | 4a. Facility Name (If not institution, give street end nur LOTIEN NUTSING HOME 5. Social Security Number 454-41-2640 Usual Residence of Decedent 10a. Stete 10b. County Md. Howard 10e. Street and Number 6334 Cedar Lane 11. Marital Status 1 Never Married 1 Never Marri | 4a. Facility Name (If not institution, give street end number) Lorien Nursing Home 5. Social Security Number 454-41-2640 Usual Residence of Decedent 10a. Stele 10b. County Md. Howard 10c. City Md. Howard 10c. City Md. Howard 10c. City Md. Howard 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 12. Secondary (0-12) 13. Widowed 4 Divorced 14. Specify only highest grede completed) 15. Decedent's Education (Specify only highest grede completed) 15. Lementary/Secondary (0-12) 15. Lementary/Secondary (0-12) 15. Lementary/Secondary (0-12) 15. Lementary/Secondary (0-12) 15. Lementary/Secondary (0-12) 15. Lementary/Secondary (0-12) 15. Lementary/Secondary (0-12) 16. Unobtainable) 19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19b. Lementary/Secondary (0-12) 20b. Pint (0-12) 20c. Method of Disposition 1 | 48. Facility Name (If not institution, give street end number) Lorien Nursing Home 5. Social Security Number 454-41-2640 10 | 4a. Facility Name (if not institution, give street and number) LOTIEN NUTSING HOME 5. Social Security Number 454-41-2640 454-41-2640 454-41-2640 454-41-2640 454-41-2640 454-41-2640 454-41-2640 454-41-2640 454-41-2640 455-4-41-2640 465-4-41-2640 465-4-41-2640 475- | 48. Facility Name (In col institution, give street end number) Lorien Nursing Home 5. Social Security Number 454-41-2640 1 | 46. City, Town, or Localion of Deal Columbia 5. Social Security Number 454-41-2640 10 M 2 Cyc 72 Yrs Months 10 Bays 10 Bays 10 Months 10 Bays 10 | Lorien Nursing Home 5. Social Security Number 6. Sext 454-41-2640 10M 20K 72 | Lorien Nursing Home 5. Social Security Number 46. Soy, Town, or Localison d Beath 47. App (in yrs. last brindsy) 48. Social Security Number 48. Social Security Number 48. Social Security Number 48. Social Security Number 48. Social Security Number 48. Social Security Number 48. Social Security Number 48. Social Security Number 48. Social Security Number 48. Social Security Number 48. Social Security Number 48. Social Security Number 48. Social Security Number 68. Social Security Number 48. Social Security Number 69. Social Security Number 69. Social Security Numbe |

State Registrar 32. Registrar's Signature

James de